

042004

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be attached for use as the burial/transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, any injury, or other traumatic event, the medical examiner must be notified.

ROTTRUCK FUNERAL HOME
85 S. MAIN STREET
KEYSER, WVA 26726

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 0 0 0 1

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LEONA ARDELLA ALLEN			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 28, 1986		2b. HOUR 1:16 P
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Apr 30 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY Candy Corp.	
13a. STATE WV	13b. COUNTY Mineral	13c. CITY OR TOWN Keyser	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 12 North Main Street 26726	
14. FATHER'S NAME FIRST MIDDLE LAST Homer Boettner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Iman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No --	16b. SOCIAL SECURITY NO. 235-16-0885	17. INFORMANT 1080 Georgia Avenue Delores Seibel Keyser, WV 26726			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia & Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1/28 86	
22a. I certify that (I) (this hospital) attended the deceased from 1/28 1986, to 1/28 1986, that (I) (we) last saw the deceased alive on 1/28 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Richard Schmitt		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/29/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD SCHMITT, M D		22e. ADDRESS 900 SETON DRIVE, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/31/86	23c. NAME OF CEMETERY OR CREMATORY Potomac Memorial Gardens	23d. LOCATION CITY OR TOWN COUNTY STATE Keyser Mineral WV	23e. DATE RECEIVED BY REGISTRAR FEB 05 1986	
24. FUNERAL DIRECTOR NAME ADDRESS A. Craig Rotruck 85 S Main St Keyser, WV 26726					

MEDICAL CERTIFICATION

DHMH - 16 60M 7/84
(VRA 15, 4)

101000 PUNJABI ROAD
83 S. MAIN STREET
KEYSTONE, ILL. 62250

012000

JANUARY 28, 1988 1:16 P

ALLEN

ROBERTA

LEWIS

ATTORNEY GENERAL

SACRED HEART HOSPITAL



PO BOX 2000, CUMBERLAND, MD 21522

RICHARD SCHULTZ, M.D.

031111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and fill them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elroy Hilry Barnes			2a. DATE OF DEATH MONTH DAY YEAR January 24, 1986		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 21, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Coal		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1001 Harding Ave. 21502	
14. FATHER'S NAME FIRST MIDDLE LAST Gust Hilry Barnes			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Mulledy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- 214-07-4977		17. INFORMANT ADDRESS David M. Barnes same as 13a-e.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic obstructive Pulmonary Disease, Atrial Fibrillation</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>N.A. Kanjithan</u>		DEGREE		22c. DATE SIGNED 1/24/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N.A. Kanjithan MD.		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/27/86		23c. NAME OF CEMETERY OR CREMATORY Branch Mountain	
23d. LOCATION CITY OR TOWN COUNTY STATE Springfield Hampshire W. VA.		24. FUNERAL DIRECTOR NAME Leasure-Stein Funeral Home		25a. DATE REC'D. BY REGISTRAR JAN 29 1986	
230 Baltimore Ave. Cumberland, MD 21502		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

022101

FOR
1 - STATE
REGISTRAR

Scarpelli Funeral Home
108 Virginia Avenue
Cumberland, Md. 21502

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harold J Barnes			2a. DATE OF DEATH MONTH DAY YEAR 01 10 86		2b. HOUR 03:55PM
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 01-13-1906		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) construction foreman		12b. KIND OF BUSINESS OR INDUSTRY Telephone Co.
13a. STATE MD		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Howard C. Barnes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora B. Davisson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 190108514		17. INFORMANT ADDRESS Mrs. Beulah Barnes, Cumberland, MD - wife	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute Atherosclerotic MI DUE TO, OR AS A CONSEQUENCE OF (c) Severe CHD coronary MI (infarct) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2d
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes II - large cell carcinoma of Rt lung - lymphangitic spread					
19a. DATE OF OPERATION 11/13/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Right Lung Cancer Prox		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/13/86 to 11/10/86 , that (I) (we) last saw the deceased alive on 11/13/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.					
22b. SIGNATURE Dr. V. Rual Felipa				22c. DATE SIGNED 1/12/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. V. Rual Felipa				22e. ADDRESS 925 Bishop Walsh Road, Cumberland, Md. 21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 01-13-1986	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502				25. DATE REC'D. BY REGISTRAR JAN 16 1986	

02216

San Francisco, California
108 Valencia Avenue
San Francisco, Cal. 94102

03 10 10 03 03 03

Harold
Lester

Allegory, Oregon



George West Longford

10 00000



Dr. V. Paul Poling

225 Bishop Blvd, San Francisco, Cal. 94102

10 0 10 0

014035

FOR
1 - STATE
REGISTRAR

Silcox Merritt Funeral Service
404 Decatur Street
Cumberland, Md. 21502

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John Joseph Beck			2a. DATE OF DEATH MONTH DAY YEAR January 02, 1986			2b. HOUR 01:55am				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT 23 1932		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		6. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD				
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) KELLY SPRINGFIELD TIRE CO.		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RFD #3 BEDFORD ROAD 21502	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN M. BECK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE PEARL NORTHCRAFT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) KOREAN WAR 217-30-2140		17. INFORMANT ADDRESS DOROTHY BECK RFD 3 BEDFORD ROAD CUMBERLAND MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PSEUDOMONAS SP. Bacteremia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Squamous Cell Carcinoma of Tongue. Right Pneumectomy. Severe Bronchospasm.</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Dr. Kenneth Zienkiewicz</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED JAN 2, 1986		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Kenneth Zienkiewicz						22e. ADDRESS 925 Bishop Walsh Road, Cumberland, Md. 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JAN 4 1986		23c. NAME OF CEMETERY OR CREMATORY ROCKY GAP VET CEMETERY		23d. LOCATION FLINTSTONE RFD ALLEGANY MARYLAND			
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.						25a. DATE REC'D. BY REGISTRAR JAN 7 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		

MEDICAL CERTIFICATION

35

14

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon duplicate of page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

014032

John Joseph Beck Thursday 07 12:00:00

Allegheny County

General Health Department

1 217-30-2140

0

Dr. Kenneth W. Winkler 328 Bridge Street, Cranford, N.J. 07016

022079

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SILCOX/MERRITT FUNERAL HOME STATE OF MARYLAND				86 00005			
1- FOR STATE REGISTRAR 404 DECATOR STREET CUMBERLAND, MD 21502				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MABEL EDNA BECK				2a. DATE OF DEATH MONTH DAY YEAR JANUARY 14 1986			
3. SEX FEMALE				2b. HOUR 10:30 AM			
4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 22 1907		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED S.T. LITTLE JEWELRY STORE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILSON W. WARNER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA GRIFFITH		13e. STREET ADDRESS / ZIP CODE 808 EDGEWOOD DRIVE 21502			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-38-0230		17. INFORMANT ADDRESS BEVERLY BAUER RFD 3 BOX 134K CUMBERLAND MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cystadenocarcinoma / ovary</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mon</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>June 14 1986</u> to <u>Jan 14 1986</u> , that (I) (we) lost above. (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE <u>W C Spiggle</u> DEGREE _____				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Jan 14 86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W C Spiggle				22e. ADDRESS BMG 912 SETON DRIVE, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN 16 1986		23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MARYLAND	
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 17 1986 <u>John Andrew Rodette</u>			

03207

SILCOX BERRY FURNACE
401 DECATUR STREET
CAMBRIDGE, MD 21613

TABEL ENA SECH

JANUARY 1986

10:30 A

ALLEANY COUNTY

SACRED BERRY HOSPITAL



X

THE BIG BROTHER, CAMBRIDGE, MD 21613

031103

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84
(VRA 15, 4)

BOALS FUNERAL HOME				STATE OF MARYLAND			
1 - STATE REGISTRAR 111 CHURCH ST. WESTERNPORT, MD. 21562				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			
DECEASED NAME (TYPE OR PRINT)				REG. NO.			
BILLIE NMI BRASHEAR				7a. DATE OF DEATH JANUARY 22, 1986			
3. SEX MALE				7b. HOUR 7:10P			
4. RACE WHITE				5. DATE OF BIRTH AUGUST 14 1930			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				6. AGE (IN YEARS LAST BIRTHDAY) 55			
7b. CITIZEN OF WHAT COUNTRY? USA				8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.			
10. CITY OR TOWN OF DEATH CUMBERLAND				9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				17a. USUAL OCCUPATION (GIVE MOST OF WORKING LIFE) CHAUFFEUR			
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND 12b. COUNTY ALLEGANY 12c. CITY OR TOWN WESTERNPORT				17b. KIND OF BUSINESS OR INDUSTRY TRUCKING			
13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13b. STREET ADDRESS / ZIP CODE 215 MILLER ST. 21562			
14. FATHER'S NAME WILLIAM BRASHEAR				15. MOTHER'S MAIDEN NAME ERMA MILLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 215266232			
17. INFORMANT ADDRESS LOLA BRASHEAR WESTERNPORT, MD. 21562							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma, primary site unknown				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21a. INJURY OCCURRED				21b. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				21d. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE GARY WAGONER, M.D.				22c. DATE SIGNED 1-24-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY WAGONER, M.D.				22e. ADDRESS 925 BISHOP WALSH RD. CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1/25/86			
23c. NAME OF CEMETERY OR CREMATORY MILLER CEMETERY				23d. LOCATION WESTERNPORT ALLEGANY MD.			
24. FUNERAL HOME BOALS FUNERAL SERVICE, P.A. WESTERNPORT, MD.				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			

BP

JAN 29 1986

081100

BEALS FURNACE ROOM
111 CHURCH ST.
DETROIT, MI 48202

7:10P JANUARY 22, 1976 BRASHEAR WAT BILLIE

22 JAN 1976

ALBANY COUNTY

x

SACRED HEART HOSPITAL

12 31 PM '76

x

225566220

x

522 BISHOP WALSH RD. CUMBERLAND, MD 21502

GARY WILCOX, M.D.

1/22/76

036046

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) AUGUST TRAGO BRUST, JR.			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 30, 1986		2b. HOUR 1:54A _M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR October 9, 1918		6. AGE (IN YEARS (LAST BIRTHDAY)) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Editor/P.R. Dir.	12b. KIND OF BUSINESS OR INDUSTRY Newspaper & Westvaco	
13a. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 120 Greene Street / 21502	
14. FATHER'S NAME FIRST MIDDLE LAST August Trago Brust, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olive Barber			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II	17. INFORMANT ADDRESS Anna Brust-Address same as #13 above.			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiomyopathy arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Aspiration</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MI</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ASCD DD</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1-29</u> 19 <u>86</u> to <u>1-30</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>1-29</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Dr. Williams</u>		DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>30 Jan 86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. T. WILLIAMS		MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2-2-86	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland-Allegany Co.-MD.		
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Maryland 21502		25a. DATE REC'D. BY REGISTRAR FEB 03 1986	25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be completed as such.

030016

WATER COTTON BUREAU

WATER COTTON BUREAU



WATER COTTON BUREAU

WATER COTTON BUREAU

209

FEB 12 1964

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

020236

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT S. BUCCI			2a. DATE OF DEATH MONTH DAY YEAR January 8, 1986		2b. HOUR 8:12 A.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 7 1934		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 51	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) salesman		12b. KIND OF BUSINESS OR INDUSTRY auto parts	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE PA		13b. COUNTY Somerset		13c. CITY OR TOWN Meyersdale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Nick Bucci		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa Emanuele		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 185-26-8178	
17. INFORMANT Nick Bucci		18. ADDRESS 311 21st St. Windber, PA 15963		19. STREET ADDRESS / ZIP CODE RD#1 15552 99999			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac/Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) N/A							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d) N/A Hypertension							
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I, OR PART 2) N/A		21d. LOCATION STREET CITY OR TOWN COUNTY STATE N/A	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21g. LOCATION STREET CITY OR TOWN COUNTY STATE N/A		21h. LOCATION STREET CITY OR TOWN COUNTY STATE N/A	
22a. I certify that (I) (this hospital) attended the deceased from 12/24/85 19____ to 1/8/86 19____, that (I) (we) last saw the deceased alive on 1/8/86 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. Figueroa / Dr. Howard Diener				22c. DEGREE MD		22d. DATE SIGNED 1/8/86	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Figueroa / Dr. Howard Diener				22f. ADDRESS Memorial Hospital Med. Bldg. Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 11, 1986		23c. NAME OF CEMETERY OR CREMATORY St. Anthony's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Windber Somerset PA	
24. FUNERAL DIRECTOR NAME Joseph R. Della Valle				24b. ADDRESS Windber, PA 15963		25a. DATE REC'D. BY REGISTRAR JAN 14 1986	
				25b. REGISTRAR'S SIGNATURE John R. Della Valle			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

999999
DHMH - 76 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified.

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(1)

024153

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 4/83
(VRA 15, 4)

Eichhorn Funeral Home 8 East Main St Lonaconing, MD 21539				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Sarah Jenkins Buckholtz				2a. DATE OF DEATH MONTH DAY YEAR January 14, 1986		2b. HOUR 3:10A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 MONTH 7 DAY 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		12a. USUAL OCCUPATION (TYPE OF BUSINESS, OCCUPATION, OR VOCATION DURING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. CITY 13c. ZIP CODE Md Allegany Lonaconing				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME Joseph Henry Jenkins				15. MOTHER'S MAIDEN NAME Elizabeth Toll			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (DATE OF BIRTH OR DATES) None		17. INFORMANT Elizabeth Kinney 1083 Woodrow, Pontiac, Mich. 48054			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Central alveolar hypoventilation syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHF & effusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>12-23</u> , 19 <u>86</u> , to <u>1-14</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>1-13</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d/d) (did not) view the body after death.							
22b. SIGNATURE <u>Uriel Velandia</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-14-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Uriel Velandia, M.D.				22e. ADDRESS 924 Seton Drive Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 1-16-86		23c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park		23d. LOCATION Cumberland and Allegany Md.	
24. FUNERAL DIRECTOR Eichhorn Funeral Home, Lonaconing, Md. <u>James E. McKenney</u>				25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 20 1986 <u>J. H. Henderson</u>			

1000 Main St
Lawrence, MO 64503

James
Joseph
Elizabeth
January 14, 1928
3:10 PM

female
white
1904

DOB

Chamberlain
James Earl Chamberlain
x

James Chamberlain
x

Joseph Henry Chamberlain
Elizabeth

James Chamberlain
Elizabeth

Elizabeth Kinney 1928

1000 Main St
Lawrence, MO 64503

1000 Main St
Lawrence, MO 64503

JANUARY 14, 1928

1000

041049

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15-ME (5))
20M-4/82

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Loretta Mae Burgess			MONTH DAY YEAR 1-25-1986			2047M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	8. MONTH DAY YEAR	2d. HOUR
F	W	MONTH DAY YEAR 5 21 21	LAST BIRTHDAY 64 YRS.	MONTHS DAYS	HOURS MIN	1-25-1986	2047M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		
MD.		USA		WIDOWED NEVER MARRIED DIVORCED		Allegany MD		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Cumberland		Memorial Hospital				Housewife		Home
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
MD.			Allegany	Flintstone	YES NO	Flintstone, MD. 21530		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Lester A. Boggs			FIRST MIDDLE LAST Rettie E. Mallow					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
(YES, NO, OR UNKNOWN) No			(IF YES, GIVE WAR OR DATES) 214-34-1568			Blaine Burgess Flintstone, MD. 21530		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES NO	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
			HOUR A.M. MONTH DAY YEAR P.M. 19					
21d. INJURY OCCURRED WHILE NOT WHILE AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
					STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Francisco Reyes			M.D. Deputy			1-25-86		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Francisco Reyes			900 Seton Dr. Cumberland Md. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial			1-28-86		Boggs Cemetery		Seneca Rocks, Pendleton W.VA.	
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
NAME ADDRESS Silcox-Merritt 404 DEcatur St Cumb Md. 21502			FEB 03 1986			John Davidson Pendleton		

017054

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
1- STATE REGISTRAR				2- DATE OF DEATH			
3- DECEASED NAME (TYPE OR PRINT)				4- DATE OF DEATH			
5- DECEASED NAME (TYPE OR PRINT)				6- DATE OF DEATH			
7- DECEASED NAME (TYPE OR PRINT)				7a- DATE OF DEATH			
8- DECEASED NAME (TYPE OR PRINT)				7b- HOUR			
9- DECEASED NAME (TYPE OR PRINT)				8- AGE (IN YEARS LAST BIRTHDAY)			
10- DECEASED NAME (TYPE OR PRINT)				9- BALTIMORE CITY OR COUNTY OF DEATH			
11- DECEASED NAME (TYPE OR PRINT)				10- USUAL OCCUPATION			
12- DECEASED NAME (TYPE OR PRINT)				11- KIND OF BUSINESS OR INDUSTRY			
13- DECEASED NAME (TYPE OR PRINT)				12a- USUAL OCCUPATION			
14- DECEASED NAME (TYPE OR PRINT)				12b- KIND OF BUSINESS OR INDUSTRY			
15- DECEASED NAME (TYPE OR PRINT)				13a- STATE			
16- DECEASED NAME (TYPE OR PRINT)				13b- COUNTY			
17- DECEASED NAME (TYPE OR PRINT)				13c- CITY OR TOWN			
18- DECEASED NAME (TYPE OR PRINT)				13d- INSIDE CITY LIMITS?			
19- DECEASED NAME (TYPE OR PRINT)				13e- STREET ADDRESS / ZIP CODE			
20- DECEASED NAME (TYPE OR PRINT)				14- FATHER'S NAME			
21- DECEASED NAME (TYPE OR PRINT)				15- MOTHER'S MAIDEN NAME			
22- DECEASED NAME (TYPE OR PRINT)				16a- WAS DECEASED EVER IN U.S. ARMED FORCES?			
23- DECEASED NAME (TYPE OR PRINT)				16b- SOCIAL SECURITY NO.			
24- DECEASED NAME (TYPE OR PRINT)				17- INFORMANT			
25- DECEASED NAME (TYPE OR PRINT)				18- CAUSE OF DEATH			
26- DECEASED NAME (TYPE OR PRINT)				19- DATE OF OPERATION			
27- DECEASED NAME (TYPE OR PRINT)				20- CONDITION FOR WHICH OPERATION WAS PERFORMED			
28- DECEASED NAME (TYPE OR PRINT)				21- ACCIDENT WAS UNDERLYING			
29- DECEASED NAME (TYPE OR PRINT)				22- TIME OF INJURY			
30- DECEASED NAME (TYPE OR PRINT)				23- HOW INJURY OCCURRED			
31- DECEASED NAME (TYPE OR PRINT)				24- INJURY OCCURRED			
32- DECEASED NAME (TYPE OR PRINT)				25- PLACE OF INJURY			
33- DECEASED NAME (TYPE OR PRINT)				26- LOCATION			
34- DECEASED NAME (TYPE OR PRINT)				27- CERTIFY THAT (I) (this hospital) attended the deceased from			
35- DECEASED NAME (TYPE OR PRINT)				28- SIGNATURE			
36- DECEASED NAME (TYPE OR PRINT)				29- PHYSICIAN'S NAME			
37- DECEASED NAME (TYPE OR PRINT)				30- ADDRESS			
38- DECEASED NAME (TYPE OR PRINT)				31- BURIAL, CREMATION, REMOVAL			
39- DECEASED NAME (TYPE OR PRINT)				32- DATE			
40- DECEASED NAME (TYPE OR PRINT)				33- NAME OF CEMETERY OR CREMATORY			
41- DECEASED NAME (TYPE OR PRINT)				34- LOCATION			
42- DECEASED NAME (TYPE OR PRINT)				43- FUNERAL DIRECTOR			
43- DECEASED NAME (TYPE OR PRINT)				44- DATE REC'D. BY REGISTRAR			
44- DECEASED NAME (TYPE OR PRINT)				45- REGISTRAR'S SIGNATURE			

BP

017054

RECEIVED

NOV 100-203

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SILVER-MURPHY FINEARTS
800 BEACON STREET
CAMBRIDGE, MA 02139

CHARLES FREDERICK BARNETT

JANUARY 2, 1982

11:20 A

ALLEGANY COUNTY

SACRED HEART HOSPITAL

705-01-1276

CLARKSON, ID 2102
310 DENT DRIVE, INC

JAN 8 1982
JAN 8 1982

041012

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMM - 16 50M 4/83
(VRA 15, 4)

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove certificates. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified and a medical examiner's certificate must be obtained.

MEDICAL CERTIFICATION

SILCOX MERRITT FUNERAL HOME 404 DECATUR ST CUMBERLAND, MD 21502				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 000012			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH				2b. HOUR			
I. DECEASED NAME (TYPE OR PRINT) WINFIELD I BURTON				JANUARY 29, 1986				9:30 PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 26 1896		6. AGE (IN YEARS LAST BIRTHDAY) 89		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OWNER CLOTHING STORE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND				13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 103 FOREST DRIVE SUNSET VIEW 21501	
14. FATHER'S NAME FIRST MIDDLE LAST ERVIN J. BURTON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISA LAW							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW1				16b. SOCIAL SECURITY NO. 214 05 7870		17. INFORMANT ADDRESS HAZEL BURTON 103 FOREST DRIVE CUMBERLAND MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CAD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Ca prostate. Cerebrovascular disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Palmos</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/31/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. PETER PALMOS				22e. ADDRESS 1 MEMORIAL DR. CUMBERLAND, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB 1 1986		23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MD.					
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL HOME				ADDRESS CUMBERLAND, MARYLAND		25a. DATE REC'D. BY REGISTRAR FEB 04 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Rodgers</u>			

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JANUARY 25, 1966

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) GERTRUDE BUSH			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 27, 1986		2b. HOUR 6:17A	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 08/30/1926		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PANAMA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		
13a. STATE PA		13b. COUNTY BEDFORD		13c. CITY OR TOWN HYNDMAN		
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM BENJAMIN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELFRIEDA LONG				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 166-32-2738		17. INFORMANT ADDRESS CHARLES E. BUSH, JR, BOX 291, HYNDMAN, PA 15545		
18. CAUSE OF DEATH (Enter only one cause per line for Part I and Part II. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) SPINAL MUSCULAR ATROPHY DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE BRONCHITIS, PNEUMONIA						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SUPRA VENTRICULAR TACH 4278						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1 JAN 86 to 27 JAN 86 that (I) (we) last saw the deceased alive on 26 JAN 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated						
22b. SIGNATURE Dr. Gore		22c. DEGREE MD		22d. DATE SIGNED 1/28/86		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DR. GORE		22f. ADDRESS Memorial Hospital, Cumberland, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/30/86		23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery		
23d. LOCATION Hyndman, Bedford, PA		23e. STATE PA		23f. DATE REC'D. BY REGISTRAR 1/28/86		
24. FUNERAL DIRECTOR NAME Harvey H. Zeigler		24b. ADDRESS Hyndman, PA 15545		24c. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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RECEIVED

PAUL M. J. J.



028006

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem performed.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

BOALS FUNERAL HOME				STATE OF MARYLAND			
1 - STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
111 CHURCH STREET				CERTIFICATE OF DEATH			
WESTERNPORT, MD 21552				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT)				2a DATE OF DEATH		2b HOUR	
ELIZABETH LORETTA CARTER				JANUARY 21, 1986		1:11 P.M.	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS
Female	White	3 15 1898		87	MONTHS DAYS		HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	U.S.A.			ALLEGANY COUNTY MD			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland	SACRED HEART HOSPITAL			Lonaconing Silk		Silk	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
Maryland				Allegany		Midland	
14 FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Thomas P. Coorigan				Laura Foutz			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS			
no		220-10-1766		Mrs. Rose Noland Midland, Md. 21542			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>PULMONARY METASTASIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ENDOMETRIAL CARCINOMA OF UTERUS</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>DEC. 17</u> , 19 <u>85</u> , to <u>JAN. 21</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>JAN. 20</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>S Chang</u>				DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>1/21/86</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) SATURNINA CHANG, MD				22e ADDRESS FROSTBURG PLAZA, FROSTBURG, MD 21532			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
Burial		1/24/86		St. Joseph Cemetery		Midland Allegany Md.	
24 FUNERAL DIRECTOR NAME <u>Boals Funeral Service Westernport, Md.</u>				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
				JAN 24 1986		<u>[Signature]</u>	

JAN 24 1986

023006

BOALS RURAL HOME
111 CLEGG STREET
WESTPORT, CT 06892

ELIZABETH LORETTA CARTER
WILMINGTON, CT 06892

3 12 1988

WILMINGTON COUNTY

SACRED HEART HOSPITAL

WILMINGTON, CT 06892

WILMINGTON, CT 06892

12-1-1988

SATURNIA CIVIC, CT
FROSTBURG PLAZA, FROSTBURG, MD 21332

12-1-1988

12-1-1988

024186

DURST FUNERAL HOME #15, Film State of Maryland
 1- FOR STATE 57 FROSS AVE.
 REGISTRAR FROSTBURG, MD 21532
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WALTER DUDLEY CAVERT			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 10, 1986			2b. HOUR 2:10 P _M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 18, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Minister		12b. KIND OF BUSINESS OR INDUSTRY Church			
13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN La Vale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William I. Cavert			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Brann De Ridder			13e. STREET ADDRESS / ZIP CODE 710 La Vale Terr., 21502			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes W.W. 1		16b. SOCIAL SECURITY NO 123-28-0081		17. INFORMANT ADDRESS Elizabeth Adams, La Vale Md. 21502					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>pneumonia bilateral</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>CHF, DSCVD, diabetes</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE <i>Shin Kim</i>			DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHIN KIM			22e. ADDRESS 90 MAIN STREET WESTERNPORT, MD 21562						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Jan. 11 '86		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg, Md.		
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.			25a. DATE REC'D. BY REGISTRAR JAN 20 1986			25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permits. Then please attach this page to the back of the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above, any injury or other traumatic event, the medical examiner must be notified at once.

BP

021130

FIRST FURNAL HOUSE

27 FRONT AVE.

BRISTOL, CT 06010

WALTER EMMERY GAVERT

JANUARY 10, 1988

1:10 P

ALBANY COUNTY

SACRED HEART HOSPITAL

153-28-0001

SHIN KIM

80 MAIN STREET
BRISTOL, CT 06010

JAN 10 1988

HAND 000

037176

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR		FOR		000016	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE	
John		Arthur		Clair	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
Male	Cau	MONTH DAY YEAR	LAST BIRTHDAY	MONTHS	DAYS
		7 1 31	54 YRS.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	9 BALTIMORE CITY OR COUNTY OF DEATH	
USA - Maryland	USA	WIDOWED	DIVORCED	Allegany MD	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland	200 Avirett Ave Cumberland Md	Painting Contractor(self emp)			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Allegany	Cumberland	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	200 Avirett Ave	21502
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST	FIRST MIDDLE LAST				
William Thomas Clair	Bessy A. Simpson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		
Yes	215-26-9382	Lois Marlene Eversole	Rt 2 Box 243		
		Ridgley West Virginia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardio-pulmonary arrest				sudden	
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b) Acute gastro-esophageal hemorrhage		1 hour	
		DUE TO, OR AS A CONSEQUENCE OF			
		(c) Barrett's esophagus with hiatal hernia		1-2 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
Ventriculomegaly(hydrocephalus): Coronary artery heart disease					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?			
10/3085	Hiatal hernia/Barret's esophagus	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
	P.M. 19				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION			
		CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion					
TITLE (SPECIFY) M.D. Dpty MEDICAL EXAMINER					
DATE SIGNED 2/1/86					
EXAMINER'S NAME (TYPE OR PRINT) Paul Snow, M.D. ADDRESS Memorial Hospital, Cumberland Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Removal	2/1/86		CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
Anatomy Board	Balto., Md.	FEB 05 1986	Julia Hudson-Rodale		

07/84
25A

BP
DHMH - 17
(VR A15 ME (5))

51170

4

041051

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TINA Elenora CLINE			2a. DATE OF DEATH MONTH DAY YEAR Jan. 25, 1986		2b. HOUR a.m. p.m. 9:00 a.m.	
3. SEX Female		4. RACE Cau		5. DATE OF BIRTH MONTH DAY YEAR July 7 1916		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY --
13a. STATE WV		13b. COUNTY Mineral		13c. CITY OR TOWN Keyser		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John W. Cowgill		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary S. Sunderlin		16. SOCIAL SECURITY NO. 236-82-2010		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 236-82-2010		17. INFORMANT ADDRESS David V. Cline, Sr. 1410 Terri Street Keyser, WV 26726		
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UNCONTROLLED SEPSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) PROBABLE CHRONIC CHOLECYSTITIS DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 11
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: RESPIRATORY FAILURE 2° VIRAL PNEUMONIA						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EXISTING, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WORKING <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from 1/24 1986 to 1/25 1986 that (1) (we) last saw the deceased alive on 1/24 1986 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)						
22b. SIGNATURE Dr. James Raver		DEGREE M.D.		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/29/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. James Raver		22e. ADDRESS 600 Memorial Ave. Cumberland, Md. 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/28/86		23c. NAME OF CEMETERY OR CREMATORY Potomac Memorial Gardens Keyser Mineral WV		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME A. Craig Rotruck		ADDRESS 85 S Main St Keyser, WV 26726		25a. DATE RECEIVED BY REGISTRAR FEB 04 1986		
				25b. REGISTRAR'S SIGNATURE Jane Davidson-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

036049

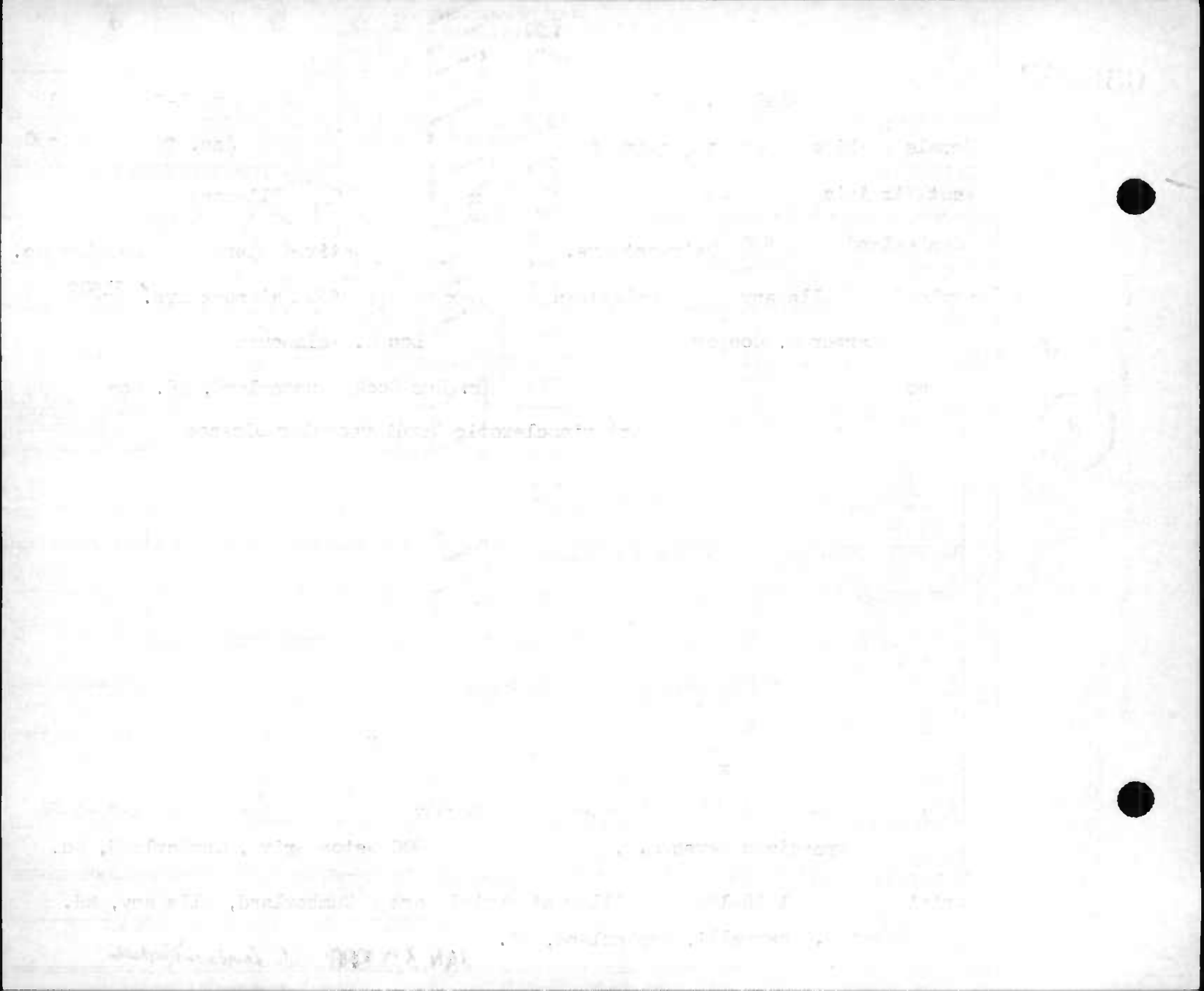
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 1 HOUR AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 10. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Ethel E. Cook										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <input checked="" type="checkbox"/> 1-26 19 86		2b. HOUR 1P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 16, 1917		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 68		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR Jan. 26 19 86		2d. HOUR 230P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 550 Fairmont Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Clerk				12b. KIND OF BUSINESS OR INDUSTRY Jewelry Co.	
13a. STATE Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 550 Fairmont Ave. 21502			
14. FATHER'S NAME FIRST MIDDLE LAST Harper J. Cooper						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lou W. Welshouse							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Gus Cook, Cumberland, Md. Son							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Arteriosclerotic Cardiovascular Disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Francisco Reyes				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER 900 Seton Drive, Cumberland, Md.				DATE SIGNED 1-26-1986	
EXAMINER'S NAME (TYPE OR PRINT) Francisco Reyes M.D.				ADDRESS									
23a. BURIAL, CREMATION, REMOVAL SPECIES Burial				23b. DATE 1-28-1986		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park				23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR NAME James F. Scarpelli						ADDRESS Cumberland, Md.		25a. DATE REC'D. BY REGISTRAR JAN 30 1986		25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall			



031057

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE BODY. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Samuel C. Cousins										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 1-17 86	
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 2, 1929		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 56		IF UNDER 1 YR. MONTHS DAYS 0 0		IF UNDER 24 HRS. HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany	
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Tire Ind.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Oldtown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 1 21555	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel M. Cousins						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Woods					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 212-24-2194		17. INFORMANT ADDRESS Mrs. Madeline Cousins, Oldtown, Md Wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a) only and (b) only) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Giovanni Mastrangelo</i>						TITLE (SPECIFY) Deputy		MEDICAL EXAMINER		DATE SIGNED 1-17-1986	
EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo M.D.						ADDRESS 912 Seton Drive, Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-18-1986		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John [Signature]</i>			

BP

JAN 27 1986

[illegible]

037177

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 0 0 2 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVELYN M. CRITES			2a. DATE OF DEATH MONTH DAY YEAR January 27, 1986		2b. HOUR 5:30 P.M.	
3 SEX F	4 RACE W	5 DATE OF BIRTH MONTH DAY YEAR 5 10 14		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD		
10 CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE W. Va.		13b. COUNTY Hardy	13c. CITY OR TOWN Moorefield	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Rt. 1, Box 168 26836	
14. FATHER'S NAME FIRST MIDDLE LAST George Benjamin Weese		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Elizabeth Ours		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 234-42-9834		17. INFORMANT ADDRESS W. Va. 26836 Robert S. Crites, Rt. 1, Box 168, Moorefield				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Subarachnoid Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Intracranial aneurysm DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Rheder Ashker, MD.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/30/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Augusto Figueroa		22e. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-30-86	23c. NAME OF CEMETERY OR CREMATORY Scott Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Durgon, Moorefield, Hardy, W. V.	
24. FUNERAL DIRECTOR NAME John A. Elmore, 217 Winchester, Moorefield, W.V.		4444444444		25a. DATE REC'D. BY REGISTRAR FEB 04 1986		
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward entire papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

26A 301104 EHEM



029038

1 -
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 0 0 2 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMMA C. DANNER			2a. DATE OF DEATH MONTH DAY YEAR 01 24 86		2b. HOUR 1:45^P M	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 06 16 03		6. AGE (IN YEARS LAST BIRTHDAY) 82
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL & MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Construction
13a. STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Danner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louisa Bachman			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 214-05-6378		17. INFORMANT ADDRESS George Bill Danner Spring Gap, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Heart Disease						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) GI bleeding (b) Alzheimer's Disease						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1-24 19 86 to 1-24 19 86 that (I) (we) last saw the deceased alive on 1-24 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE [Signature]		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-24-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. J. Barrera M. D.		22e. ADDRESS Memorial Ave., Cumberland, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 27, 1986		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial P.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD
24. FUNERAL DIRECTOR NAME William G. Kight Cumberland, MD		25a. DATE REC'D. BY REGISTRAR JAN 27 1986				
25b. REGISTRAR'S SIGNATURE [Signature]						

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept for 27 hours after the death. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

003038

01 24 80	DAWNER	White	Female
82	16 03	USA	MD
Allegany			
Construction	MEMORIAL HOSPITAL & MEDICAL CENTER Bookkeeper	CUMBERLAND	
1009 Bedford St. 21202	X	ALLEGANY	CUMBERLAND
Bachman	Louisa	Danner	Charles
George Bill Danner Spring Gap, MD	No		



William G. Knight Cumberland, MD
Jan. 27, 1986 Wilkeest Burial P. Cumberland Allegany MD
K. J. Barrens M. D. Memorial Ave., Cumberland, MD

036018

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 0 0 2 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DESSIE RAY DAYTON			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 29, 1986		2b. HOUR 2:40A.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7 26 1910		6. AGE (IN YEARS LAST BIRTHDAY) 75	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? usa	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County	
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) General Services		12b. KIND OF BUSINESS OR INDUSTRY Naval Exchange
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Westernport	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 134 Wood St. 21562	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Dayton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Dawson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO. 216-09-7631 A	17. INFORMANT ADDRESS Mrs. Frances Greaves Westernport, Md 21562		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Possibly advanced small cell Ca. Lung. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)					
22b. SIGNATURE <i>[Signature]</i> MD				22c. DATE SIGNED 1/29/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ZAMAN				22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2/1/86	23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Westernport Allegany Md.		
24. FUNERAL DIRECTOR NAME Boals Funeral Service			25a. DATE RECD. BY REGISTRAR FEB 03 1986	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed in the funeral director's office. Page 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as (a), (b), or (c), it shows any injury, or other traumatic event, the medical examiner should be notified and also the coroner.

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x
The County
In every person

1000 1000 1000 1000
x
The County
In every person



030013
The County
In every person

036050

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 0 0 2 3

REG. NO.

1. DECEASED NAME (TYE OR RINT) MX Helen E Debenham			2a. DATE OF DEATH MONTH DAY YEAR 1/25/86			2b. HOUR 6:20 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10/4/92		6. AGE (IN YEARS LAST BIRTHDAY) 93		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? United State		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD			
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1 Kaylor Circle, Frostburg, MD 21532	
14. FATHER'S NAME FIRST MIDDLE LAST OSCAR READING		15. MOTHER'S MAIDEN NAME FIRST MIDDLE ANNA WENNERMARK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO N.A.		17. INFORMANT MRS. MURIEL BALLASES, MIDLOTHIAN, MD		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2/22 , 19 83 , to JANUARY , 19 86 , that (I) (we) last saw the deceased alive on JANUARY 9 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE S. Chang				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYE OR RINT) Dr. S. Chang				22e. ADDRESS Frostburg, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 1/28/86		23c. NAME OF CEMETERY OR CREMATORY SMITHBURG CREMATORIUM		23d. LOCATION CITY OR TOWN COUNTY STATE SMITHBURG, WASHINGTON, MD			
24. FUNERAL DIRECTOR M. Sowers Sowers Funeral Home				60 W. MAIN ST. FROSTBURG		25. DATE REC'D. BY REGISTRAR JAN 30 1986		25b. REGISTRAR'S SIGNATURE Gelia Davidson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the death certificate must be filed with the State Dept. of Health and Mental Hygiene.

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031006

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove completing parts, pages 1 and 2, and bring them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 27 is marked on item 18 showing any injury, or other traumatic event, the medical examiner must be notified of this.

Price Funeral Home		STATE OF MARYLAND		000024	
1. FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		CERTIFICATE OF DEATH	
PO BOX 119 Meyersdale, PA 15552		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Michael Demarco				January 17, 1986	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Male		White		Feb. 7m 1905	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS	
Italy		USA		80	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Cumberland		Sacred Heart Hospital		Allegany County, MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE	
Distributor		Produce		212 Broadway 99999	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Pa.		Somerset		Meyersdale	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. SOCIAL SECURITY NO.	
Jacob DeMarco		Marietta Sicoli		220100849	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		220100849		Mary DeMarco 212 Broadway Meyersdale, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Carcinoma of colon c metastasis					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
John Mehanna, M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
John Mehanna, M.D.		909-B Seton Drive, Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		Jan. 20-86		Country Side Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Davidsville, Somerset, Pa.		JAN 27 1986		John Davidson-Randall	
24. FUNERAL HOME OR ADDRESS		25. DATE REC'D. BY REGISTRAR			
Price Funeral Home 325 Main St. Meyersdale, Pa. 15552		JAN 27 1986			

DHMH - 16 50M 4/83 (VRA 15, 4)

TO BOX 112
MONTANA, 59102

1990: 1991

Journal of Health Politics, Policy and Law

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates, pages 1 and 2, and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified.

DURST FUNERAL HOME
FROSTBURG, MD 21532

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8600025

1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BENJAMIN CARL DENNISEAR		Male		White		April 5, 1907		78 YRS		W. Virginia		U.S.A.				ALLEGANY COUNTY MD.		Cumberland		SACRED HEART HOSPITAL		Textile		Celanese	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE																	
Maryland		Allegany		Mt. Savage		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		P.O. Box 431, 21545																	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																							
Benjamin F. Dennisear		Rebecca Eisentrout																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT																					
Yes		W.W. 2		216-09-4402		Rosetta Dennisear, Same as 13e																			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b) and 1c.)		PART I. DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF																							
Sudden cardiac death		C.H.F.																							
DUE TO, OR AS A CONSEQUENCE OF		C.A.D. Atrial fibrillation																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																					
		HOUR A.M. MONTH DAY YEAR																							
		P.M.		19																					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION																					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE															
22a. I certify that (I) (this hospital) attended the deceased from		22b. DATE SIGNED																							
saw the deceased alive on 1-13-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		1-13-86																							
22c. SIGNATURE		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																					
[Signature]		DR. U. VELANDIA MD		924 SETON DRIVE, CUMBERLAND, MD 21502																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION																			
Burial		Jan. 16 '86		Methodist Cemetery		Mt. Savage, Allegany, Md.																			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																					
NAME		ADDRESS		JAN 20 1986		John Anderson-Randall																			
Durst Funeral Home, Frostburg, Md.																									

BP

WEST BURLINGTON
FROSTBURG, MD 21533

021193

10:30 A JANUARY 17, 1988

DEWISER

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RECEIVED

ALLEANY COUNTY

SACRED HEART HOSPITAL



324 SETON DRIVE, CUMMERTON, MD 21502

DR. J. VELANDIA JR.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 0 0 2 6

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) CATHERINE VICTORIA DENSORE			2a DATE OF DEATH January 3, 1986		2b HOUR 11:55 PM	
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH 8/15/03	6 AGE (IN YEARS LAST BIRTHDAY) 82	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10 CITY OR TOWN OF DEATH Cumberland	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a STATE MARYLAND	13b COUNTY ALLEGANY	13c CITY OR TOWN WOODLAND	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE RT. 1, BOX 268	21532	
14 FATHER'S NAME THOMAS		15 MOTHER'S MAIDEN NAME IDA BELLE FLEEGLER		ADDRESS 21532		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N.A.	17 INFORMANT MRS. BETTY ALLEN, RT. 1, FROSTBURG, MD				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Recurrent Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pulmonary Edema</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Anemia & Gastrointestinal Bleeding</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>History of diabetes mellitus, prev. episodes of Congestive heart failure</i>						
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <i>Richard Schindler</i>		DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 1-4-86		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Richard Schindler		22e ADDRESS 69 Greene Street Cumberland, MD 21502				
23a BURIAL, CREMATION, REMOVAL BURIAL	23b DATE 1/17/86	23c NAME OF CEMETERY OR CREMATORY FROSTBURG MEM PARK	23d LOCATION CITY OR TOWN COUNTY STATE FROSTBURG ALLEGANY MD	23e DATE REC'D. BY REGISTRAR JAN 9 1986		
24 SIGNATURE OF REGISTRAR <i>Julia Davidson-Randall</i>		25 REGISTRAR'S SIGNATURE				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove complete pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			7b. HOUR			
George William Deremer						1986			1 1			1053A			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR	
Male		Cau		7 15 17		68 YRS.		MONTHS DAYS		HOURS MIN.		1 1 1986		1053A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia				U.S.A.				WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				Allegany			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland				Memorial Hospital				U.S. Air Force & Kelly-Springfield							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
West Va				Mineral		Keyser		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt 2 Box 199 / 26726					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
Charles				Sarah				E. Daniels							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT							
Yes				Military Career				220-10-7166 Ilse D. Deremer-Address same as #13 above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:												sudden			
IMMEDIATE CAUSE (a) Cardio-pulmonary arrest															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												years			
(b) Coronary artery heart disease															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I															
Aortic stenosis; hyper-tension															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED							
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				HOUR A.M. MONTH DAY YEAR				ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2							
				P.M. 19											
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>				STREET, FACTORY, FARM, ETC.]				CITY OR TOWN COUNTY STATE							
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				MEDICAL EXAMINER				DATE SIGNED			
Paul Snow, M.D.				M.D. Upty								1-1-86			
EXAMINER'S NAME				ADDRESS											
(TYPE OR PRINT)				Paul Snow, M.D.				Memorial Hosp. Cumberland Md 21502							
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial				1-4-86		Ft. Ashby Cemetery				Ft. Ashby-Mineral-West Virginia					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
George-Upchurch Funeral Home, P.A.				JAN 6 1986											
202 Greene Street-Cumberland, Maryland 21502															

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1 - FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) CHARLES S. DETRICK			2a DATE OF DEATH MONTH DAY YEAR January 16, 1986		2b HOUR 12:15 P.M.
3 SEX male	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR 08-22-1920		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10 CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ret. carman		12b KIND OF BUSINESS OR INDUSTRY railroad
13a STATE WV	13b COUNTY Mineral	13c CITY OR TOWN Ridgeley	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE Route 1 Box 184B/26753	
14 FATHER'S NAME FIRST MIDDLE LAST Charles S. Detrick, Sr.			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lilly F. Deter		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes	16b SOCIAL SECURITY NO (IF YES GIVE WAR OR DATES) WW II 214-16-2764	17 INFORMANT ADDRESS Mrs. Flora M. Detrick, Cumberland, MD -wife			
18 CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO OR AS A CONSEQUENCE OF (b) Morbid Acid M.I. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Slightly Acidosis					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE Jan 16 86 Jan 16 86	
22a I certify that (I) (this hospital) attended the deceased from Jan 16 86 to Jan 16 86 , that (I) (we) last saw the deceased alive on Jan 16 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not attend the body after death.)					
22b SIGNATURE Terry Williams		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 1-17-86	
23a PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Terry Williams			22e ADDRESS Memorial Hospital Med. Bldg. Cumberland, MD 21502		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 01-19-1986	23c NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		
24 FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502			25a DATE REC'D. BY REGISTRAR JAN 20 1986		
			25b REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, or medical condition, the body must be marked and preserved.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card and page 4 from this certificate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 checked as any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERNICE MARY DEVORE			2a. DATE OF DEATH MONTH DAY YEAR January 10, 1986		2b. HOUR 9:05 A	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 09/09/08		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Gilbert A. Rohrbaugh		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Addie Cole		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		
16a. SOCIAL SECURITY NO. 213-12-9279		17. INFORMANT ADDRESS Ina Canada, Box 14, Ellerslie, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) METABOLIC ENCEPHALOPATHY						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.						
22b. SIGNATURE <i>Dr. Amado Torres</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/10/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Amado Torres		22e. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/13/86		23c. NAME OF CEMETERY OR CREMATORY Cooks Mills Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE RD, Hyndman, Bedford, PA
24. FUNERAL DIRECTOR NAME Harvey H. Zeigler		ADDRESS Hyndman, PA		25a. DATE REC'D. BY REGISTRAR JAN 14 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anna Digioia			2a. DATE OF DEATH MONTH DAY YEAR 1 13 86			2b. HOUR 7:45 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 10 06		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Alegany County MD.			
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY School	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Luke		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 339 Fairview St., 21540	
14. FATHER'S NAME FIRST MIDDLE LAST John Eagan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes O'Neil			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 217-30-2089			17. INFORMANT ADDRESS 2613 Redmiles Dr. Mary K. Gardner, Silver Spring, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septicemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>3 days</u> DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Dialysis Ketoacidosis - old age</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>84</u> to <u>1/13</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/12</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>S. Lal Sandhir</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/13/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Lal Sandhir			22e. ADDRESS 48 Tarn Terrace Frostburg, MD 21532						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Jan. 14 '86		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg, Md.		
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.			25a. DATE REC'D. BY REGISTRAR JAN 20 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the remaining pages. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

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Hafer Funeral Home
1 - STATE REGISTRAR 1302 National Hwy
Lavale, MD 21502

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 0 0 0 3 1

1. DECEASED NAME (TYPE OR PRINT) Otto Droege			2a. DATE OF DEATH MONTH DAY YEAR January 10, 1986			2b. HOUR 2:45A_M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10- 3- 1892		6 AGE (IN YEARS LAST BIRTHDAY) 93 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (# NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
USUAL RESIDENCE (# NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13. STREET ADDRESS / ZIP CODE 214 Park St/ 21502	
14. FATHER'S NAME FIRST MIDDLE LAST (Unknown) Droege					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Rust				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES AND OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (# NOT GIVEN WAR OR DATES) WW 1		17. INFORMANT ADDRESS Ruth E. Droege--same as above				
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Constrictive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Long									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Ischemic heart disease									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (# EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/10/86 to 1/10/86 , that (I) (we) lost saw the deceased alive on 1/10/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. Espina, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/10/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Renato Espina, M.D.						22e. ADDRESS 907 Seton Drive Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan 12, 1986		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Alleg., Md.		
24. FUNERAL DIRECTOR John J. Hafer, Jr Lavale, Md 21502						25a. DATE REC'D. BY REGISTRAR JAN 16 1986		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

024156

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE KNOWN OF DEATH				2b. HOUR			
FIRST MIDDLE LAST Virginia Madeline Eaton				MONTH DAY YEAR 1 13 19 86				2306			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	Cau	Dec 21 1898	87 YRS.	MONTHS	DAYS	HOURS	MIN	1 13 19 86		2306	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia		U.S.A.		WIDOWED		DIVORCED		Allegany MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		Memorial Hospital				Postmistress		U.S. Mail			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
West Virginia		Morgan		Paw Paw		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 1 Box 33			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Charles Whisner				FIRST MIDDLE LAST Ollie Henry							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				233-40-9327		Mr. James W. Parr Paw Paw, W. Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cardiac arrest											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) Cardiac arrhythmia											
DUE TO, OR AS A CONSEQUENCE OF											
(c) Aortic stenosis											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
Fracture left clavicle, 30 hours											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR 1400hrs 1/12 1986		patient fell at home					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
				home		Box 33		Paw Paw		West Virginia	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Paul Snow, M.D.				Dpt				1/13/86			
EXAMINER'S NAME				ADDRESS							
Paul Snow, M.D.				Memorial Hosp. Cumberland Md 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial				1/16/86		Woodrow Cemetery		Paw Paw Morgan W. Va.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
James R. Dyles				JAN 20 1986		Augusta, W. Va.					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. IF THE DEATH IS SUSPECTED, THE MEDICAL EXAMINER SHOULD BE NOTIFIED IMMEDIATELY. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))

1886

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x

East Virginia

Assoc. of

Assoc. of

x

Assoc. of

Henry

Ohio

Whitman

Charles

223-40-9327 Mr. James W. Smith Jan 1 1886

do

223-40-9327



1-16-86

Smith

1886

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Department of Health and Mental Hygiene, Baltimore, Maryland. Page 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

024201

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph M. Edwards			2a. DATE OF DEATH MONTH DAY YEAR January 11, 1986		2b. HOUR M AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 9, 1923		
6. AGE (IN YEARS LAST BIRTHDAY) 62		7. UNDER 1 YEAR MONTHS DAYS YRS.		8. UNDER 24 HRS. HOURS MIN. YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Nursing Home		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Textile		12b. KIND OF BUSINESS OR INDUSTRY Celanese				
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		
14. FATHER'S NAME FIRST MIDDLE LAST Robert L. Edwards		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie Mc Gee		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W.W. 2 217-18-4499		17. INFORMANT ADDRESS Glenna Edwards, Same as 13c		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Severe COPD and Emphysema DUE TO, OR AS A CONSEQUENCE OF (c) Acute Respiratory Infection						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Acute Respiratory Infection						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Dec 18, 1986 to 1/11/1986 , that (I) (we) last saw the deceased alive on Dec 18, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.						
22b. SIGNATURE S.L. Sandhir		DEGREE M.D.		22c. DATE SIGNED 1/13/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.L. Sandhir, M.D.		22e. ADDRESS 48 Tarn Terrace, Frostburg, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Jan. 12 '86		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematory Smithsburg, Md.		
23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg, Md.		23e. NAME OF REGISTRAR OR REGISTRAR'S SIGNATURE Jane D. ...				
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.		ADDRESS JAN 20 1986				

John V. Lee

John V. Lee

John V. Lee

John V. Lee

John V. Lee

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(3)

John V. Lee

009062

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH DAY YEAR			2b. HOUR											
EMILY M. EVANS						1 5 186						M											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR									
Female		Cau		03-29-1899		86 YRS.						1 5 86		1530 M									
7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
PA				USA								Allegany MD											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
Cumberland				208 Fairfax Street				housewife				own home											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS							
Maryland				Allegany				Cumberland				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				208 Fairfax Street 21502							
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST								FIRST MIDDLE LAST															
John Bolbach								Susanna Frinafrock															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)								16b. SOCIAL SECURITY NO.								17. INFORMANT							
no								212-74-4013								Charles R. & Wm. J. Evans, Cumberland, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																							
PART I DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																							
(b) <u>Cardiac arrhythmia</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c) <u>Cardio-vascular heart disease</u>																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																							
<u>Chronic renal failure; recent sepsis under treatment</u>																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?											
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)															
				P.M. 19																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION															
								STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																							
TITLE (SPECIFY)																							
M.D. Dpty MEDICAL EXAMINER																							
DATE SIGNED 1/5/86																							
ACTUAL SIGNATURE																							
EXAMINER'S NAME (TYPE OR PRINT) Paul Snow, M.D.																							
ADDRESS Memorial Hosp. Cumberland Md 21502																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION											
Burial				01-08-1986				Sunset Memorial Park				Cumberland Allegany MD											
24. FUNERAL DIRECTOR																							
NAME ADDRESS																							
James F. Scarpelli, Cumberland, MD 21502																							
25a. DATE REC'D. BY REGISTRAR																							
25b. REGISTRAR'S SIGNATURE																							
JAN 8 1986 Julia Davidson																							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. PAGES 1, 2, AND 3 SHOULD BE FILED WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

330800

BOX COTTON FIBER

NOV 10 1944

NEW YORK



Handwritten notes at the bottom left, possibly including a date or reference number.

020060

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. GIVE PAGE 5 TO THE FUNERAL DIRECTOR. PAGE 6 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH ESTI- MATED										2b. HOUR																			
1. DECEASED NAME (TYPE OR PRINT)										2c. DATE PRONOUNCED DEAD										2d. HOUR																			
LILLIE MARIE FLETCHER										1 8 1986										9:15 M																			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			IF UNDER 1 YR.			IF UNDER 24 HRS.			7c. DATE PRONOUNCED DEAD			2d. HOUR																		
Female			Cau.			9 15 08			77 YRS.			MONTHS			DAYS			HOURS			MIN																		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH																								
Penna.					USA										Allegany																								
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY																			
Cumberland					537 Eastern Ave.										Housewife					Home																			
13a. STATE										13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET ADDRESS														
Md.										Allegany					Cumberland					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					537 Eastern Ave. 21582														
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																													
Joseph Owen Shipley										Clara Virginia Shaffer																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.										17. INFORMANT																			
No										214-05-9876-B										Mrs. Shirley Wigfield Williams Rd. Cumb.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART I DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)										Arteriosclerotic Cardiovascular																			
										DUE TO, OR AS A CONSEQUENCE OF																													
										(b) Disease																													
										DUE TO, OR AS A CONSEQUENCE OF																													
										(c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																			
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
										P.M. 19																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION																			
																				STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																																							
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																			
Francisco Reyes										M.D. Deputy										1-8-86																			
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																													
Francisco Reyes										900 Seton Dr. Cumberland Md.																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION									
Burial										1-10-86										Hillcrest Burial Park										Cumberland Allegany Md.									
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																			
Silcox-Merritt Funeral Home - Cumberland Md.										JAN 13 1986										Julia Davidson-Rodriguez																			

[Faint, illegible text covering the page, possibly bleed-through from the reverse side.]

021082

HAFER FUNERAL HOME

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 0 0 3 6

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CYRUS Edwin FRANKENBERRY			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 13, 1986		2b. HOUR 2:25P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 11, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY Celanese	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Mt. Savage	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas L. Frankenberry		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dortha Miller		13e. STREET ADDRESS / ZIP CODE Route 1, Box 88 / 21545	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214075596	17. INFORMANT ADDRESS Virginia Crump - Mt. Savage, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Renal failure & U.T.I.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WORKER <input type="checkbox"/> NOT WORKER <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 13</u> 19 <u>86</u> to <u>Jan 13</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Jan 13</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.					
22a. SIGNATURE <u>Chang Oh, M.D.</u>		DEGREE M.D.		22c. DATE SIGNED 1/14/86	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) CHANG OH, M.D.		22e. ADDRESS 48 TARN TERRACE FROSTBURG, MD. 21532			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 16, 1986	23c. NAME OF CEMETERY OR CREMATORY Mt. Savage Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Savage, Alleg., MD
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr.		ADDRESS 21502 LaVale, MD		25a. DATE REC'D. BY REGISTRAR JAN 17 1986	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

021082

THREE FURNACE HTS
72 FRONT AVE.
FROSTBURG, MD. 21332

FRANKLIN COUNTY
JANUARY 12, 1968
2:30 PM

July 14, 1968

ALLEANY COUNTY

SECRETARY'S OFFICE
FROSTBURG, MD. 21332

FRANKLIN COUNTY
JANUARY 12, 1968

FRANKLIN COUNTY
JANUARY 12, 1968

FRANKLIN COUNTY
JANUARY 12, 1968

Handwritten notes and signatures

2020-01-13

CHIEF OF POLICE

25

1

CHIEF OF POLICE
FROSTBURG, MD. 21332

FRANKLIN COUNTY
JANUARY 12, 1968

FRANKLIN COUNTY
JANUARY 12, 1968

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

0 0 0 3 7

041029

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MICHELE FRANZE			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 27, 1986		2b. HOUR 11:25A_M	
1. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 01-02-1886		6. AGE (IN YEARS LAST BIRTHDAY) 100 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) Italy	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD		
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ret. trackman		12b. KIND OF BUSINESS OR INDUSTRY railroad	
13a. STATE MD	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 313 South Cedar Street/21502		
14. FATHER'S NAME FIRST MIDDLE LAST Natale Franze		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Seminara				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 705-09-7044		17. INFORMANT ADDRESS Mrs. Frances Franze, Cumberland, MD - wife		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Lower GI bleeding						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1-25-86 1-27-86		
22a. I certify that (I) (this hospital) attended the deceased from 1-25-86 to 1-27-86 , that (I) (we) last saw the deceased alive on 1-27-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE H. J. Warner, Jr.				DEGREE MD		22c. DATE SIGNED 1-29-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. BARRERA				22e. MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 01-30-1986		23c. NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery		23d. LOCATION CITY OR TOWN COUNTY Cumberland Allegany MD
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502				25a. DATE REC'D. BY REGISTRAR FEB 03 1986		25b. REGISTRAR'S SIGNATURE John Barber

0110



031022

DIVISION OF VITAL RECORDS, 300 WESTBOSTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 300 WESTBOSTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA FRANCES FREE										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 01-19 19 86	
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 06-11-1899		6. AGE (IN YEARS) (LAST BIRTHDAY) 86 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 01/19/1986		24 HOUR 3:45 P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital & Medical Cent.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 109 Grand Avenue/21502			
14. FATHER'S NAME FIRST MIDDLE LAST Homer Golliday				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Frye							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-46-3564		17. INFORMANT ADDRESS Miss Norma J. Free, Cumberland, MD-daughter					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8842 IMMEDIATE CAUSE (a) Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } (b) Pneumonia and Congestive failure (c) } DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Fracture of Hip (right)											
19a. DATE OF OPERATION 01/17/86				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture Right Hip				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:00am 1/17/86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Fell from Bed in the Hospital					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) Hospital		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Memorial Ave. Cumberland, Md. Allegany Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Giovanni Mastrangelo				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER DATE SIGNED 1/19/86			
EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo, M.D.				ADDRESS 912 Seton Drive, Cumberland, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 01-22-1986		23c. NAME OF CEMETERY OR CREMATORY Hawkinstown UME Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hawkinstown VA			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502						25a. DATE REC'D. BY REGISTRAR JAN 27 1986		25b. REGISTRAR'S SIGNATURE Julia Linder-Rodell			

100-100

100-100



100-100

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100-100

031004

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the completed certificate to the State Department of Health and Mental Hygiene, 201 W. Preston St., Baltimore, Maryland 21201. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
1- STATE REGISTRAR
SILCOX-MERRITT FUNERAL HOME
404 DECATUR ST. CUMB.MD. CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GRACE REBECCA TWIGG GALL			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 21, 1986		2b. HOUR 5:45 P.M.		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 20 1898		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM KITZMILLER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA ROSENMERKLE		13e. STREET ADDRESS / ZIP CODE OLDTOWNE MANOR OLDTOWN ROAD 21502			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 220-16-5492 D		17. INFORMANT ADDRESS WILMINGTON, NORTH CAROLINA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Post. Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Post. Pulmonary Embolism.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Suddenly</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>acute aspiration Pneumonia. Suppur. Urinary Infection. Diabetic. Post CVA.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/11</u> , 19 <u>86</u> , to <u>1/21</u> , 19 <u>86</u> , that (I/we) last saw the deceased alive on <u>1/21</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>S. Sandhir</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/22/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SIKANDER SANDHIR, M.D.		22e. ADDRESS 48 TARN TERRACE FROSTBURG, MD. 21532					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN 24 1986		23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT CEMETERY		23d. LOCATION CUMBERLAND ALLEGANY MARYLAND	
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND		ADDRESS 404 DECATUR ST. CUMBERLAND MARYLAND		25a. DATE REC'D. BY REGISTRAR JAN 27 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>	

011004

STATIONER'S SUPPLY CO. 1000 N. 10TH ST. S.W. ALBUQUERQUE, N.M. 87102

ALBUQUERQUE, N.M. 87102

ALBUQUERQUE, N.M. 87102

SACRED HEART HOSPITAL

NOV 19 1964

RECEIVED
NOV 19 1964
SACRED HEART HOSPITAL



STATIONER'S SUPPLY CO. 1000 N. 10TH ST. S.W. ALBUQUERQUE, N.M. 87102

STATIONER'S SUPPLY CO. 1000 N. 10TH ST. S.W. ALBUQUERQUE, N.M. 87102

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST REGINA		MIDDLE C.		LAST GELLNER		2. DATE OF DEATH		MONTH JANUARY 25, 1986		DAY 25		YEAR 1986		2b. HOUR 12:15P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 28, 1903				6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD									
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Allegany County Nursing Home						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER				12b. KIND OF BUSINESS OR INDUSTRY Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 719 Washington Street / 21502							
14. FATHER'S NAME FIRST MIDDLE LAST Joseph F. Carbine				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary - Carney				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -									
16b. SOCIAL SECURITY NO. 214-05-8824				17. INFORMANT Rosemary C. Hill				ADDRESS 719 Washington St. Cumberland, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>A.S.C.V.D. Dementia/ Hypo cerebral Atrophy</u>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>11-24</u> , 19 <u>80</u> , to <u>1-25</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>11-24</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>V. A. Rantjithan</u>												DEGREE		22c. DATE SIGNED 1-25-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIMALA A. RANTJITHAN												22e. ADDRESS Memorial Hospital Medical Building Cumberland, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-27-86				23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland-Allegany Co., MD.					
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Md. 21502												25a. DATE REC'D. BY REGISTRAR JAN 29 1986		25b. REGISTRAR'S SIGNATURE <u>Chia Davidson-Rendell</u>			

MEDICAL CERTIFICATION

BP_____

HMH - 16 50M 4/83
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner's report may be sought at once.

[Faint, illegible handwriting on lined paper]

020237

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

SHAFFER FUNERAL HOME

1 - FOR STATE REGISTRAR 230 E MAIN STREET
ROMNEY, WV 26757STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

00041

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hester Ann Glaze			2a. DATE OF DEATH MONTH DAY YEAR January 9, 1986			2b. HOUR 1:10A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 6, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD			
12. CITY OR TOWN OF DEATH Cumberland		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		15. KIND OF BUSINESS OR INDUSTRY Home	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE WV 13b. COUNTY Hampshire 13c. CITY OR TOWN Greenspring					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rural 99999 26722		
14. FATHER'S NAME FIRST MIDDLE LAST Pent Z Kerns					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Etta Robinson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 234623929		17. INFORMANT ADDRESS WV 26753 Beatrice Whitacre, Rt. 2, Box 479, Ridgeley,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure with</u> DUE TO, OR AS A CONSEQUENCE OF, <u>malfunction of PACE MAKER.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PE lower lobe pneumonia for</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PE lower lobe pneumonia for</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>NO</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12-30</u> , 19 <u>86</u> , to <u>1-9</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1-8</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Uriel Velandia</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1-9-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Uriel Velandia, M.D.					22e. ADDRESS 924 Seton Drive, Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/12/86		23c. NAME OF CEMETERY OR CREMATORY Forest Glen Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Greenspring Hampshire WV			
24. FUNERAL DIRECTOR Keith S. Shaffer NAME ADDRESS Shaffer Funeral Home, Romney, WV 26757					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE				

BP

DHWH-16 50M 4/83
(VRA 15, 4)

030137

SHARPER FUNERAL HOME
230 E MAIN STREET
BONNEY, IDAHO 83725

AD-1

January 2, 1988

Phone

Area

Number

Alameda County

Sacred Heart Hospital

234623859

234623859, 234623859, 234623859

234623859, 234623859, 234623859

041038

1- FOR STATE REGISTRAR
Durst Funeral Home
57 Frost Ave
Frostburg, MD 21532

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 6 0 0 0 4 2

REG NO

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Walter Aloysius Grahame			2a. DATE OF DEATH MONTH DAY YEAR January 23, 1986		2b. HOUR 10:18 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 31, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditor		12b. KIND OF BUSINESS OR INDUSTRY Race Track	

13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 631 Columbia Ave., 21502			
14. FATHER'S NAME FIRST MIDDLE LAST John Colin Grahame			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Malloy			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 166090535		
17. INFORMANT Paul Miller, Cumberland, Md. 21502						ADDRESS 829 Columbia Ave					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min 10 d year	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Prev Cardiac arrest, COPD, Prosthetic Hypertension, Senility							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Victor E. Mazzocco		DEGREE M.D.		22c. DATE SIGNED 1-28-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Victor E. Mazzocco, M.D.		22e. ADDRESS BMG, 912 Seton Drive, Cumberland, MD 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 27 '86		23c. NAME OF CEMETERY OR CREMATORY St. Michaels Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Frostburg, Allegany, Md.	
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24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.		25. DATE RECD. BY REGISTRAR FEB 03 1986	
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

014008

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Rhoda C. Dayton Gross			2a. DATE OF DEATH MONTH DAY YEAR Jan. 4 1986		2b. HOUR P 12:30 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH July 6, 1901	6. AGE (IN YEARS LAST BIRTHDAY) 84	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
10. CITY OR TOWN OF DEATH Pinto	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS) Maple Lane	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY In Own Home		
13a. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Pinto	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Maple Lane 21556	
14. FATHER'S NAME FIRST MIDDLE LAST Norman S. Yoder		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Yoder			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 236-58-0889	17. INFORMANT ADDRESS Daughter Mrs. Virginia D. Moreland, Pinto, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Ventricular Arrhythmia					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21i. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) the hospital attended the deceased from Dec 22, 1985, to Jan 4, 1986, that (1) last saw the deceased alive on Jan 4, 1986, and that in (my) own opinion death occurred on the date and hour and from the causes stated above; (2) we (did) not view the body after death.					
22b. SIGNATURE Paul T. Livengood MD		DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Jan 5 1986
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Paul T. Livengood		22e. ADDRESS 912 Seton Drive, Cumberland, Md. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-7-1986	23c. NAME OF CEMETERY OR CREMATORY Pinto Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Pinto, Allegany, Md.		
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md. 21502		25a. DATE REC'D. BY REGISTRAR Jan 8 1986	25b. REGISTRAR'S SIGNATURE Julia Davidson-Pendley		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

029033

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. (EARLY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 9. SEND PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2b. DATE KNOWN OF DEATH			2c. DATE PRONOUNCED DEAD			2d. HOUR		
Murray Leonard E. Grouden			1 24 1986			1 24 1986			18:29		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7. BALTIMORE CITY OR COUNTY OF DEATH			8. HOUR		
M	W	1 28 13	72 YRS.			Allegany			18:29		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			10. CITIZEN OF WHAT COUNTRY?			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Penna.			USA			Memorial Hospital			Ret. Clerk		
13. CITY OR TOWN OF DEATH			14. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			16. KIND OF BUSINESS OR INDUSTRY		
Cumberland			Memorial Hospital			Ret. Clerk			Rail Road		
17. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			18. INSIDE CITY LIMITS?			19. STREET ADDRESS			20. CITY OR TOWN		
Penna. Bedford			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. # 3			15522		
21. FATHER'S NAME			22. MOTHER'S MAIDEN NAME			23. SOCIAL SECURITY NO.			24. INFORMANT		
John Ewing Grouden			Myrtle Bell Rice			705-10-7323			Maxine Sweitzer Cumberland, MD		
25. WAS DECEASED EVER IN U.S. ARMED FORCES?			26. SOCIAL SECURITY NO.			27. INFORMANT			28. ADDRESS		
No			705-10-7323			Maxine Sweitzer Cumberland, MD					
29. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart disease and</u>											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Calcific Aortic stenosis</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
									YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION					
						CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED					
Francisco Reyes			Deputy			1-24-86					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS								
Francisco Reyes			900 Seton Dr. Cumberland, Md 21502								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		
Burial			Jan. 28, 1986			Centenary Cemetery			Cumberland Allegany MD		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
William G. Kight			Cumberland, MD			JAN 27 1986			John G. Grouden		

DMH - 17
(VR A15 ME (5))
20M 4/82

Allegany

USA

Penns.

Mail Road

Rec. Clerk

15522

X Rt. # 3

Bedford

Penns Bedford

Rice

Beil

Myrtle

Gowden

Swing

John

702-10-7323 Machine Sweitzer Cumberland, MD

No

Jan. 28, 1986 Centenary Cemetery Allegany, MD

William G. Knight Cumberland, MD

022126

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN BRACKET IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1- FOR STATE REGISTRAR										00045	
1 DECEASED NAME (TYPE OR PRINT) BEATRICE MAY HARDEN										2a DATE KNOWN OF DEATH MONTH DAY YEAR <input checked="" type="checkbox"/> MONTH DAY YEAR DEATH MATED <input type="checkbox"/> 1 10 1986	
3 SEX FEMALE 4 RACE WHITE 5 DATE OF BIRTH MONTH DAY YEAR 8/18/18 6 AGE (IN YEARS) LAST BIRTHDAY 67 YRS.										2b HOUR 6:PM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA 7b CITIZEN OF WHAT COUNTRY? U.S.A. 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										2c DATE PRONOUNCED DEAD MONTH DAY YEAR 1-10 1986 2d HOUR 7:15	
9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD											
10 CITY OR TOWN OF DEATH MORANTOWN 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RT. 3, BOX 465, FROSTBURG 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE 12b KIND OF BUSINESS OR INDUSTRY OWN HOME											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND 13b COUNTY ALLEGANY 13c CITY OR TOWN MORANTOWN 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e STREET ADDRESS RT. 3, BOX 465, FROSTBURG										21532	
14 FATHER'S NAME FIRST MIDDLE LAST IRA KENDALL 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PEARL COLLINS											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO N.A. 16b SOCIAL SECURITY NO. 217-14-4548 17 INFORMANT MRS. HILDA GORDON, ECKHART, MD										ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) POSSIBLY STROKE (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK										21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f LOCATION STREET CITY OR TOWN COUNTY STATE											
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Francisco Reyes TITLE (SPECIFY) DEPUTY M.D. MEDICAL EXAMINER										DATE SIGNED 1-10-86	
EXAMINER'S NAME (TYPE OR PRINT) FRANCISCO REYES ADDRESS 900 Seton Dr. Cumberland Md.											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b DATE 1/13/86 23c NAME OF CEMETERY OR CREMATORY PORTER CEMETERY 23d LOCATION CITY OR TOWN COUNTY STATE ECKHART ALLEGANY MD											
24 FUNERAL DIRECTOR W. MAIN ST. 25a DATE REC'D. BY REGISTRAR JAN 16 1986 25b REGISTRAR'S SIGNATURE SOWERS FUNERAL HOME FROSTBURG											

07-84
25M

BP

DHMH - 17
(VR A15 ME (1))

001130



014009

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00046

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Francis Emil Haselberger			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Jan. 1 1986			2b. HOUR M		
3 SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 9, 1909	6. AGE (IN YEARS) (LAST BIRTHDAY) 76 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR Jan. 3 1986	2d. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
10. CITY OR TOWN OF DEATH La Vale		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route 1, Box 23, Gramlich Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Clerk		12b. KIND OF BUSINESS OR INDUSTRY U.S. Postal Dept.	
13a. STATE Maryland			13b. COUNTY Allegany	13c. CITY OR TOWN La Vale	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt. 1, Box 23, Gramlich Road
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Haselberger				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Mc Kenna				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-10-5383		17. INFORMANT ADDRESS Daughter Mrs. Constance Smith, Clarksville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Cardiac Arrythemia (b) Coronary Artery Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes; High Blood Pressure PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes; High Blood Pressure							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden Years	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Paul Snow</i>		TITLE (SPECIFY) Deputy		DATE SIGNED Jan. 3, 1986		M.D. MEDICAL EXAMINER Memorial Hospital, Cumberland Md.		
EXAMINER'S NAME (TYPE OR PRINT) Paul Snow M.D.		ADDRESS 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-6-1985		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, Md. 21502				25a. DATE REC'D. BY REGISTRAR JAN 8 1986		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>		

DIVISION OF VITAL RECORDS, 201 W. PRESIDENT STREET, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESIDENT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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DHMH: 17
(VR A15 ME (5))

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00047

1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2b. DATE KNOWN OF DEATH			2c. DATE OF ESTIMATED DEATH			2d. DATE OF DEATH			2e. HOUR			
FLOYD Nathan Hill			1 14 86			1 14 86			1 14 86			6:00			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		
MALE	WHITE	MAY 20 1920	65 YRS.			1 14 86	XX			ALLEGANY			CUMBERLAND		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			
MARYLAND			USA			XX			ALLEGANY			CUMBERLAND			
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. STATE			13b. COUNTY			
RFD#8 CHRISTIE ROAD			RETIRED AUTO BODY SHOP EMPLOYEE						MARYLAND			ALLEGANY			
13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			
CUMBERLAND			XX			RFD# 8 CHRISTIE ROAD BOX 123			BRETHARD			BEULAH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH			19. DATE OF OPERATION			
YES			220-10-7090			JAMES HILL RFD 8 CHRISTIE ROAD CUMBERLAND			8253			19a. DATE OF OPERATION			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Smoke Inhalation
DUE TO, OR AS A CONSEQUENCE OF
(b) Burning of car
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
		5:00 A.M. 1-14-86		Car caught on fire	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY		21f. LOCATION	
		Field		off Christie Road Cumberland Allegany MD	

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion

ACTUAL SIGNATURE Giovanni Mastrangelo TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 1-14-86

EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo, M.D. ADDRESS 900 Seton Drive, Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	23e. COUNTY	23f. STATE
BURIAL	JAN 17 1986	ROCKY GAP VETERANS CEMETERY	FLINSTONE	ALLEGANY	MD
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD		JAN 17 1986		<u>G. Davidson</u>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

COLLIER HILL

CHERRY

W. A. RAY

CHERRY



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New York, New York

041032

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 1 HOUR AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 7b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. EXAMINER'S SIGNATURE AND TITLE SHOULD BE ON PAGE 4. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 31 86		2b. HOUR 6:30	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAYMOND EVERETT HOWARD		3. SEX Male		4. RACE Cau	
5. DATE OF BIRTH MONTH DAY YEAR 12/14/12		6. AGE (IN YEARS) (LAST BIRTHDAY) 73 YRS		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD		10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 4 Box 202 Oldtown Road	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ret.		12b. KIND OF BUSINESS OR INDUSTRY railroad		13a. STREET ADDRESS Rt. 4 Box 202 Oldtown Road	
13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE (CITY LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME (FIRST MIDDLE LAST) William Virgil Howard		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Nancy Elizabeth Haynes		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no	
16b. SOCIAL SECURITY NO. 426-07-4040		17. INFORMANT Mrs. Minnie Howard, Cumberland, MD - wife		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma, lung DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		TITLE (SPECIFY) Dpty		DATE SIGNED 1/31/86	
ACTUAL SIGNATURE [Signature]		M.D. Dpty		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Paul Snow, M.D.		ADDRESS Memorial Hospital		Cumberland Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 02-03-1986		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery	
23d. LOCATION CITY OR TOWN		23e. COUNTY Allegany		23f. STATE MD	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR FEB 04 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

DND

RECEIVED

WINTER



022023

GEORGE UPCHURCH FUNERAL HOME STATE OF MARYLAND
1. FOR GREEN STREET DEPARTMENT OF HEALTH AND MENTAL HYGIENE
STATE CUMBERLAND, MD 21502 CERTIFICATE OF DEATH

8 6 0 0 0 4 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGIA GLADYS HUMES			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 7, 1986		2b. HOUR 11:00AM	
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 18, 1908		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 77 YRS.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUTNY MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Buyer			12b. KIND OF BUSINESS OR INDUSTRY Dept. Store			
13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 337 Davidson Street / 21502			
14. FATHER'S NAME FIRST MIDDLE LAST John Whally Ways			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adelaide C. George			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No --		16b. SOCIAL SECURITY NO. 214-05-8354		17. INFORMANT ADDRESS Ray Humes-315 Frederick St., Cumberland, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 887 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cronary Artery Disease - Angina</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Chronic Destructive Pulm Disease</u> PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus. Hx. Lumbar spine</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, INDICATE MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 2 OR PART 2)		
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT SCHOOL <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)		21c. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany Co. MD		
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 15, 1985</u> to <u>Jan 7, 1986</u> , that (I) (we) last saw the deceased alive on <u>Jan 7, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If) (we) did (did not) view the body after death.						
22a. SIGNATURE Chang Oh, M.D.		DEGREE M.D.		22c. DATE SIGNED Jan 7, 1986		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) CHANG OH, MD		22e. ADDRESS 48 TARN TERRACE, FROSTBURG, MD 21532				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1 = 9 = 86		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland-Allegany Co.-MD.		23e. DATE REC'D. BY REGISTRAR JAN 20 1986				
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A.		25b. REGISTRAR'S SIGNATURE				
202 Greene Street-Cumberland, Md. 21502						

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked "at home," the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for filing, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

022023

GEORGE WICHAM FARMER HOME
GREEN STREET
CLIMBERLAND RD 21802

GEORGIA

CLAYD

JAMES

JANUARY 7, 1921

ALLEGANY COUNTY

CORDED HEART HOSPITAL



46 TWIN TERRACE, HIGHTSTOWN, NJ 08520

CLARK CH. MD.

11:00AM

100% COTTON

041018

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B 6

00050

1. FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Benjamin F Huntsman			2a DATE OF DEATH MONTH DAY YEAR 1/27/86		2b HOUR 10:45 am	
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 12/01/00		6 AGE (IN YEARS LAST BIRTHDAY) 85	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b CITIZEN OF WHAT COUNTRY? United State	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD		
10 CITY OR TOWN OF DEATH Frostburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Paymaster		12b KIND OF BUSINESS OR INDUSTRY Textile	
13a STATE Maryland	13b COUNTY Alleg	13c CITY OR TOWN Frostburg	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 16 Bowery St, Frostburg, MD 21532		
14 FATHER'S NAME FIRST MIDDLE LAST Aaron Huntsman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Pelligan				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 214 07 1538		17 INFORMANT Esther O. Huntsman, Same as 13e		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.						
22b. SIGNATURE <i>[Signature]</i>		DEGREE M.P.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/27/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S. Schwartz		22e. ADDRESS Frostburg, MD 21532				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 30 '86		23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Frostburg, Md.
24 FUNERAL DIRECTOR XXXXX Durst		ADDRESS Frostburg, MD		25a. DATE REC'D. BY REGISTRAR FEB 03 1986		
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

MEDICAL CERTIFICATION

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies of pages 1 and 2 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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FEB 03 1971

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GR. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										00051			
FOR 1- STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Walter F. Hymes										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 01-17 19 86		2b. HOUR 6:17 M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 01-28-1911		6. AGE (IN YEARS) (LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 01/17/86		2d. HOUR 6:17 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD			
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ret. supervisor				12b. KIND OF BUSINESS OR INDUSTRY textile	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN LaVale		13d. INSIDE (CITY LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 101 Mary Street 21502					
14. FATHER'S NAME FIRST MIDDLE LAST Melvin Lee Hymes						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret A. Senkbeil							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-07-5057		17. INFORMANT ADDRESS Lillian M. Hymes, LaVale, MD - wife							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Giovanni Mastrangelo</u>						TITLE (SPECIFY) Deputy		MEDICAL EXAMINER		DATE SIGNED 1-17-1986			
EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo M.D.						ADDRESS 912 Seton Drive, Cumberland Md 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 01-21-1986		23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park				23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24. FUNERAL DIRECTOR NAME James E. Scarpelli						ADDRESS Cumberland, MD 21502		25. ADJUDICATED BY JAN 27 1986					

MEDICAL CERTIFICATION

1944-1945

Supervisor

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041086

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 0 0 5 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anna NMI Keyes			2a. DATE OF DEATH MONTH DAY YEAR 1/ 30/ 86			2b. HOUR 10:30 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 09 '02		6. AGE (IN YEARS LAST BIRTHDAY) 83		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) MD		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD			
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital				12a. USUAL OCCUPATION Retired Practical Nurse		12b. KIND OF BUSINESS OR COUNTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md		13b. ALLEGANY Lonaconing		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. 215 Burnace St. Formerly of 21539			
14. FATHER'S NAME James Russell		15. MOTHER'S MAIDEN NAME Nellie Russell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE DATE) None		17. INFORMANT Paul Moses Star Rt 1, Box 305, Barton, Md					
18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Aspiration Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) <u>8 Bilateral CVA with marked Contractures</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>80</u> , to _____, 19 <u>86</u> , that (I) (we) last saw the deceased alive on _____, 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>SL Sandhir</u>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/31/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Lal Sandhir, M.D.				22e. ADDRESS 48 Tarn Terrace Frostburg, MD 21532					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 2-2-86		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION Lonaconing Allegany Md			
24. FUNERAL DIRECTOR Eichhorn Funeral Home, Lonaconing, Md. <u>John E. Eichhorn</u>				25a. DATE REC'D. BY REGISTRAR FEB 06 1986		25b. REGISTRAR'S SIGNATURE <u>Wardson Rendall</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 192 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Effect of 1/2

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Effect of 1/2

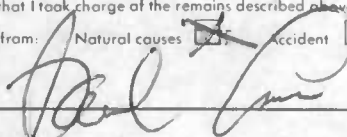
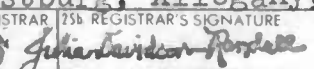
Effect of 1/2

024200

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. PAGES 1, 2, AND 3 SHOULD BE FILED WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 00053			
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET TWIGG KIDWELL										DATE KNOWN OF DEATH MONTH DAY YEAR HOUR 1 13 1986 0200			
3. SEX Female		4. RACE Cau		5. DATE OF BIRTH MONTH DAY YEAR 3 28 12		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 73		IF UNDER 1 YR. MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assist Clerk		12c. KIND OF BUSINESS OR INDUSTRY City			
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 54 Ormond Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assist Clerk		12c. KIND OF BUSINESS OR INDUSTRY City					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 54 Ormond St., 21532					
14. FATHER'S NAME FIRST MIDDLE LAST Noah S. Twigg				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Simms									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-16-2523				17. INFORMANT ADDRESS Joan L. Riley, Westernport, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) Chronic bradycardia Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden minutes 5 years													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 				TITLE (SPECIFY) Dpty				MEDICAL EXAMINER DATE SIGNED 1/13/86					
EXAMINER'S NAME (TYPE OR PRINT) Paul Snow, N.D.				ADDRESS Memorial Hosp. Cumberland Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jan. 15 '86		23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Frostburg, Allegany, Md.			
24. FUNERAL DIRECTOR NAME Durst Funeral Home				ADDRESS Frostburg, Md.				25a. DATE REC'D. BY REGISTRAR JAN 20 1986				25b. REGISTRAR'S SIGNATURE 	

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LEASURE-STEIN FUNERAL HOME STATE OF MARYLAND
 230 BALTIMORE AVE. DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CUMBERLAND, MD 21502 CERTIFICATE OF DEATH

8 6 0 0 0 5 4

1. FOR STATE REGISTRAR		20. DATE OF DEATH		21. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		20. DATE OF DEATH		21. HOUR	
IRENE MARIE KLAVUHN		01 12 86		8:36 PM.	
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		White		11-19-22	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
West Virginia		U.S.A.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Cumberland		SACRED HEART HOSPITAL		Housewife	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Allegany		Cumberland	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. STREET ADDRESS / ZIP CODE	
Charles Stuart Wilson		Anna Mae UNKNOWN		21502 1804 Holland St. Ext.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		215122106		Robert C. Klavuhn same as 13a-e.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Cardiopneum Shock</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Heart MI</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Heart Disease & Pulmonary Artery MI</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Sinus</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/12/86</u> to <u>1/12/86</u> that (I) (we) last saw the deceased alive on <u>1/12/86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>V. R. Felipa</u>				<u>1/14/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
V. R. FELIPA, M.D.		925 BISHOP WALSH ROAD, CUMBERLAND, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		1/15/86		Hillcrest Burial	
23d. LOCATION		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Cumberland Allegany MD		JAN 16 1986			
24. FUNERAL DIRECTOR NAME					
Leasure-Stein Funeral Home, Inc.					
230 Baltimore Ave. Cumberland, MD 21502					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

020057

LEASURE-THORN HOSPITAL
230 BALTIMORE AVE.
CUMBERLAND, MD 21502

IRRE JAWIE FLAVUW 02 19 88 8:38 P.M.

ALLEGANY COUNTY



RECEPTION

V. B. FELTON, M.D.

421 LESTER AVE. WEST, CUMBERLAND, MD

016044

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

00055

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH A LAMBERT			2a. DATE OF DEATH MONTH DAY YEAR January 9, 1986		2b. HOUR A 0055
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6 10 1925		6. AGE (IN YEARS (LAST BIRTHDAY)) 60	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic	12b. KIND OF BUSINESS OR INDUSTRY House	
13a. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Westernport	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Rt. 1 Box 143 21562	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Ravenscroft		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Riley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 215-42-2504	17. INFORMANT ADDRESS Mr. Lewis Lambert Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Congestive Cardiac failure. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/8</u> 19 <u>85</u> to <u>1/9</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>1/8</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Shrestha</i>		DEGREE		22c. DATE SIGNED <u>1/9/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Shrestha		22e. ADDRESS Memorial Hospital Cumberland, Md. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/11/86	23c. NAME OF CEMETERY OR CREMATORY Duckworth Cemetery		23d. LOCATION CITY OR TOWN Westernport Allegany Md. STATE	
24. FUNERAL DIRECTOR NAME Boals Funeral Service Westernport Md.		25a. DATE REC'D. BY REGISTRAR JAN 13 1986		25b. REGISTRAR'S SIGNATURE <i>Davidson</i>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be retained by the funeral director. Page 5 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal death certificate must be completed and filed with this certificate.

020234

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

00056

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGUERITE BELL LANTZ			2a. DATE OF DEATH MONTH DAY YEAR January 8, 1986		2b. HOUR 3:45 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT 18 1896		
6. AGE (IN YEARS LAST BIRTHDAY) 89		7. CITIZEN OF WHAT COUNTRY? USA		8. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.VA.		10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CELANESE CORP OF		12b. KIND OF BUSINESS OR INDUSTRY AMERICA				
13a. STATE W.VA.		13b. COUNTY MINERAL		13c. CITY OR TOWN RIDGELEY		
14. FATHER'S NAME FIRST MIDDLE LAST SAMPSON DAY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOTTIE GIBSON		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		
17. INFORMANT MARGARET VIANDS RFD 1 WILEY FORD W.VA.		18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12/26/85 to 1/8/86 , that (I) (we) last saw the deceased alive on 12/26/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.						
22b. SIGNATURE Dr. Peter Halmos		22c. ADDRESS Memorial Hospital & Medical Center Cumberland, MD 21502		22d. DATE SIGNED 1/8/86		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN 10 1986		23c. NAME OF CEMETERY OR CREMATORY REST LAWN CEMETERY		
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND		25a. DATE REC'D. BY REGISTRAR JAN 13 1986		25b. REGISTRAR'S SIGNATURE John E. ...		

050831



031012

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

SHAFFERS FUNERAL HOME

STATE OF MARYLAND

8 6

0 0 0 5 7

1- FOR STATE REGISTRAR 230 E. MAIN STREET ROMNEY, WV 26757

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLARA GENEVA LEE			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 16, 1986		2b. HOUR 3:50 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 9, 1925		
6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		10. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
12. CITY OR TOWN OF DEATH Cumberland		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		14. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE WV 15b. COUNTY Hampshire 15c. CITY OR TOWN Springfield		16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17. STREET ADDRESS / ZIP CODE Rural 26763		
18. FATHER'S NAME FIRST MIDDLE LAST Ollie R. Landis		19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Bryant Bean		20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		
21. SOCIAL SECURITY NO. 236-36-1985		22. INFORMANT Leldon I. Lee,		23. ADDRESS Springfield, WV 26763		
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sanguinous bowels</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe narrowing of Mesenteric artery</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Recent L.T. infarction</u>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Gas bubbles in bowels</u>						
25. DATE OF OPERATION 1-16-86		26. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute abdomen		27. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		32. INJURY OCCURRED 21a. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		33. LOCATION STREET CITY OR TOWN COUNTY STATE		
34. I certify that (I) (this hospital) attended the deceased from <u>1-16</u> , 19 <u>86</u> to <u>1-16</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1-16</u> , 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		35. SIGNATURE <u>John Mehan</u>		36. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
37. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MEHANNA		38. ADDRESS 909-B SETON DRIVE CUMBERLAND, MD 21502		39. DATE SIGNED 1-20-86		
40. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		41. DATE 1/19/86		42. NAME OF CEMETERY OR CREMATORY Forest Glen		
43. LOCATION CITY OR TOWN COUNTY STATE Greenspring Hampshire WV		44. FUNERAL DIRECTOR NAME Keith S. Shaffer		45. ADDRESS Shaffer Funeral Home, Romney, WV		
46. DATE REC'D. BY REGISTRAR JAN 27 1986		47. REGISTRAR'S SIGNATURE <u>John Davidson</u>		48. REGISTRAR'S NAME John Davidson		

031013

SHIPPERS FURNISH FORM
210 E. MAIN STREET
ROCKY, WY 82521

CLASS BULKW LEE

CARRIAGE 10 1000

ALLERDAY COUNTY

SACRED HEART HOSPITAL

010-28-1002

NOTICE OF
MAY 1961



RECEIVED BY 01002
MAY 1961

JOHN HENRY

JOHN HENRY

024196

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 0 0 5 8

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HELEN EVA LEGROS			2a. DATE OF DEATH MONTH DAY YEAR January 13, 1986		2b. HOUR P 12:15 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 20 1922		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own home	
13a. STATE Pa.		13b. COUNTY Bedford	13c. CITY OR TOWN Bedford	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE RD #5 Box 632 99999
14. FATHER'S NAME FIRST MIDDLE LAST Alfred Eger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Della Maillet			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 014-18-9951		17. INFORMANT ADDRESS Robert C. LeGros RD #5 Bedford, Pa. 15522	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <u>SLE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>101230</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Thrombocytopenia</u>					
19a. DATE OF OPERATION <u>Jan 11 1986</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>for Angioma</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1-17-86</u> , 19 <u>86</u> , to <u>1-13</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>1-13</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Dr. John T. Whitmore</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-13-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. John T. Whitmore		22e. ADDRESS 1068 National Hwy. La Vale, Md. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-17-86	23c. NAME OF CEMETERY OR CREMATORY St Josephs Catholic		23d. LOCATION CITY OR TOWN COUNTY STATE Pittsburg Worcester Mass.	
24. FUNERAL DIRECTOR NAME Timothy A. Berkebile		ADDRESS Bedford, Pa. 214 S. Juliana St.		25a. DATE REC'D. BY REGISTRAR JAN 20 1986	25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rodale</u>

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84
(VRA 15, 4)

021130



JAN 30 1950

017087

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00059

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE ESTIMATED			2c. DATE PRONOUNCED DEAD			2d. DATE OF DEATH		
Albert Lynch			1 6 1986			1 6 1986			1 6 1986			1201P		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			7. IF UNDER 1 YR.		
Male			Cau			SEPT 30 1914			71 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		
PENNA.			USA			X NEVER MARRIED			ALLEGANY			Cumberland		
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. STATE			13b. COUNTY		
Memorial Hospital			RETIRED KELLY SPRINGFIELD TIRE						Maryland			Allegany		
13c. CITY OR TOWN			13d. INSIDE (CITY LIMITS?)			13e. STREET ADDRESS			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
La Vale			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			14 Vocke DRIVE			CHARLES			ELIZA		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH			19. OTHER SIGNIFICANT CONDITIONS		
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			175-14-0532			MARTHA LYNCH 14 VOCKE DRIVE LA VALE MD.			Cardio-pulmonary arrest			Cardio-vascular heart disease		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			21a. EXTERNAL CAUSE WAS			21b. TIME OF INJURY		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			HOUR A.M. MONTH DAY YEAR		
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION			22a. I certify that I took charge of the remains described above, held on			22b. TIME OF INJURY		
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>			STREET, FACTORY, FARM, ETC.]			CITY OR TOWN COUNTY STATE			death resulted from			HOUR A.M. MONTH DAY YEAR		
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>									natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION			22e. DATE OF DEATH			22f. REGISTRAR'S SIGNATURE			22g. DATE OF DEATH		
ROCKY GAP VETERANS CEMET.			FLINTSTONE RFD ALLEGANY MD.			1/6/86			John Davidson-Randall			1/6/86		
23. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			23e. DATE OF DEATH		
BURIAL			JAN 9 1986			ROCKY GAP VETERANS CEMET.			FLINTSTONE RFD ALLEGANY MD.			1/6/86		
24. FUNERAL DIRECTOR			24b. ADDRESS			24c. DATE OF DEATH			24d. REGISTRAR'S SIGNATURE			24e. DATE OF DEATH		
SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.						JAN 9 1986			John Davidson-Randall			1/6/86		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE REMARKS SECTION. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PW 2, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 6 AND 7 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

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1988-1989

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1989

022119

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

0 0 0 6 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY JANE MCCLARREN			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 12, 1986		2b. HOUR 12:31 P. M
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 02-09-1928		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife	12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE MD		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 128 Virginia Avenue/21502
14. FATHER'S NAME FIRST MIDDLE LAST Roy Schucker			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola Dunlap		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 203-20-6970	17. INFORMANT ADDRESS Rev. Lloyd C. McClarren, Cumberland, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (c) <u>Mitral Valveular Disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1-4-86</u> to <u>1-12-86</u> that (I) (we) last saw the deceased alive on <u>1-4-86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.					
22b. SIGNATURE <u>James F. Scarpelli</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-13-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. BARRERA		MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 01-15-1986	23c. NAME OF CEMETERY OR CREMATORY Rosedale Funeral Chapel		23d. LOCATION CITY OR TOWN COUNTY STATE Martinsburg Berkeley WV
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		DATE REG. NO. REGISTRAR'S SIGNATURE JAN 16 1986 <u>John Davidson-Randall</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carefully the top of the certificate and place it in the folder with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic cause, the medical examiner must be notified immediately.

031130

RECEIVED FEB 11 1964

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035055

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST	MIDDLE	LAST	MONTH	DAY	YEAR	HOUR		MIN.
RICHARD LEO MCCLELLAND			January 29, 1986			2:15 A		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR
Male		White		MONTH DAY YEAR Jan. 24, 1921		65 YRS.		IF UNDER 24 HRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
Maryland		U.S.A.				Allegany MD		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Cumberland		Memorial Hospital						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland			Allegany		Cumberland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET ADDRESS / ZIP CODE		
FIRST MIDDLE LAST John Claire McClellan			FIRST MIDDLE LAST Mary Ann Fink			Rt. 8 Box 291 21502		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS		
Yes		WWII		220-10-4571		Mary Frances McClelland same as 13a-e		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adult respiratory Distress Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Viral Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Post Pneumonia, Rt. for adenocarc. of lung</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>1-29-86</u> to <u>1-29-86</u> , that (I) (we) lost saw the deceased alive on <u>1-29-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>R. J. Barrera</u>				22c. DATE SIGNED <u>1-29-86</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. R. J. Barrera, M.D.				22e. ADDRESS Memorial Hospital Med. Cumberland, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		1/31/86		Sunset Memorial park		Cumberland Alleg. MD		
24 FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Leasure-Stein Funeral Home, Inc.				JAN 31 1986		<u>Johanna Davidson-Randall</u>		
230 Baltimore Avenue Cumberland, MD 21502								

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner or coroner should also be notified.

000000

100% COTTON FIBER

CHERRY BLOSSOM



MADE IN U.S.A.

035023

FOR
1. STATE
REGISTRAR

BOALS FUNERAL HOME
111 CHURCH STREET
WESTERNPORT, MD ~~XXXX~~ 21562

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 0 0 6 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
DONALD		AUBREY		MCINTYRE				JANUARY 26, 1986					9:50A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		IF UNDER 24 HRS.		8. HOURS		MIN.
Male		White		4 30 1914		71		YRS						
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS / ZIP CODE		14. BALTIMORE CITY OR COUNTY OF DEATH		MD
Maryland		Cumberland		SACRED HEART HOSPITAL		Insurance Agent		Insurance		525 Carskaden Lane 26726		ALLEGANY COUNTY		
15a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		15b. STATE		15c. COUNTY		15d. CITY OR TOWN		15e. INSIDE CITY LIMITS?		15f. STREET ADDRESS / ZIP CODE		15g. MOTHER'S MAIDEN NAME		
West Virginia Mineral		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		525 Carskaden Lane 26726		Edna G. Ack		
16a. FATHER'S NAME		16b. SOCIAL SECURITY NO.		16c. INFORMANT		16d. ADDRESS		16e. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16f. IF YES, GIVE NAME OR DATES		16g. SOCIAL SECURITY NO.		
Aubrey C. McIntyre		375-01-8823		Mrs. Dorothy McIntyre		Keyser, W.Va. 26726		yes		WWII		375-01-8823		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Vent. fibrillation</u>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Cor. Art. Dis.</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Myocardial Infarction, Diab. Mell., C. H.P.</u>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20c. YES <input type="checkbox"/> NO <input type="checkbox"/>		20d. YES <input type="checkbox"/> NO <input type="checkbox"/>		20e. YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		21g. CITY OR TOWN		STATE
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		P.M. 19												
22a. I certify that (I) (this hospital) attended the deceased from <u>1/23</u> 19 <u>86</u> to <u>1/26</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/23</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE		22c. DEGREE		22d. ATTENDING PHYSICIAN		22e. MEDICAL DIRECTOR		22f. STAFF PHYSICIAN		22g. DATE SIGNED		22h. SIGNATURE		
C. J. Vincent MD														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. CITY OR TOWN		22g. COUNTY		22h. STATE		22i. ZIP CODE		22j. SIGNATURE		
CLARENCE VINCENT, MD		909-B SETON DRIVE, CUMBERLAND, MD 21502												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. CITY OR TOWN		23f. COUNTY		23g. STATE		
Burial		1/29/86		Philos Cemetery		Westernport		Allegany Md.						
24. FUNERAL DIRECTOR		24a. NAME		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE		24e. SIGNATURE		24f. DATE		
Boals Funeral Service		Wayne Brath		Westernport, Md. 21562		JAN 31 1986		Jana Jackson-Randall						

BOAL'S FUNERAL HOME
111 CHURCH STREET
WESTMINSTER, CO. 80551

8:50A JANUARY 26, 1988 ALBANY ALBANY COUNTY

SACRED HEART HOSPITAL

Myocardial Infarction, Stage II, C. H. F.
Can Not Do
Vital Functions
Cardiac arrest

1/23/88 1/26/88

CLARICE VINCENT, MD 805-B SEVEN DRIVE, CUMBERLAND, MD 21502

017036

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B 6 0 0 0 6 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Floyd B. McIntyre			2a. DATE OF DEATH MONTH DAY YEAR 1 8 86		2b. HOUR M 850 A
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Nov. 18, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 75	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10. CITY OR TOWN OF DEATH Frostburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Village Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Farmer		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD	13b. COUNTY Garrett	13c. CITY OR TOWN Barton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE RD 1, Box 185 21531	
14. FATHER'S NAME FIRST MIDDLE LAST John W. McIntyre		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ursula Blanche Harvey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-12-3498		17. INFORMANT ADDRESS Mary A. McIntyre, RD 1, Box 185 21531	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Polycythemia Vera					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CAD - MYO					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
22a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22c. LOCATION STREET CITY OR TOWN COUNTY STATE	
23. I certify that (a) this hospital attended the deceased from Jan 8 1986 to Jan 8 1986 that (b) we last saw the deceased alive on Jan 8 1986 and that (c) my (our) opinion death occurred on the date and hour and from the causes stated					
24. SIGNATURE Chang-hyun Oh		DEGREE MD		DATE SIGNED Jan 10 86	
25. PHYSICIAN'S NAME (TYPE OR PRINT) Chang-hyun Oh, M.D.		26. ADDRESS Frostburg, Md. 21532			
27a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial	27b. DATE 1-11-86	27c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park	27d. LOCATION CITY OR TOWN COUNTY Frostburg, Allegany, MD		
28. FUNERAL DIRECTOR NAME Eichhorn Funeral Home, Lonsdale, MD		ADDRESS 21539	29. DATE REC'D. BY REGISTRAR JAN 14 1986		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, and should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18, does any injury, or other traumatic event, or medication administered to the individual.

BP

031058

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased state be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 6 0 0 0 6 4			
1 - SCARPELLI FUNERAL HOME REGISTERAR 108 VA. AVE. CUMBERLAND, MD				CERTIFICATE OF DEATH			
1 DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
DAVID R. MCMILLAN SR.				JANUARY 19, 1986			
3. SEX male		4. RACE white		5. DATE OF BIRTH 05-30-1930		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY El. Local 307	
13a. STATE MD				13b. COUNTY Allegany		13c. CITY OR TOWN Oldtown	
14. FATHER'S NAME FIRST MIDDLE LAST David S. McMillan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie I. Myers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean		17. INFORMANT ADDRESS Mrs. Theresa L. McMillan, Oldtown, MD-wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio - Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Ca. Colon.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>				DEGREE MD		22c. DATE SIGNED 1/19/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) QAMAR ZAMAN, M.D.				22e. ADDRESS MEMORIAL MEDICAL BLDG. CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 01-22-1986		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP

SCARFELL H. ERAL HOME
108 AV. AVE. CUMBERLAND, MD.

JANUARY 18, 1901

WILLIAM ST.

DAVID

ALLEGANY COUNTY

SACRED HEART HOSPITAL

DISCHARGED

1/18/01
1/19/01
1/20/01
1/21/01
1/22/01
1/23/01
1/24/01
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1/30/01
1/31/01

METCAL MEDICAL BLDG. CUMBERLAND, MD. 2150

DAVID ZAVANI, M.D.

014011

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 0 0 6 5

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDNA LORAIN METZGER			2a. DATE OF DEATH MONTH DAY YEAR January 5, 1986		2b. HOUR 10:05 A.
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 09-04-1912		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife	12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Route 8 Box 40/21502	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Morehead		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amy Ickes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 214-62-4173	17. INFORMANT ADDRESS Mr. John V. Metzger, Cumberland, MD - husband			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>N/A</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Poor Left Ventricular Function 2+ to Cardiac Vasc. Disease</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>N/A</u> 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>N/A</u>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <u>N/A</u>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>N/A</u>	21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>N/A</u>			
22a. I certify that (I) (this hospital) attended the deceased from <u>1-4-86</u> , 19 <u>86</u> , to <u>1-5-86</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive or above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Howard Diener</u>		DEGREE <u>MD</u>	22c. DATE SIGNED <u>1/6/86</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Howard Diener
22e. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 01-07-1986	23c. NAME OF CEMETERY OR CREMATORY Rocky Gap V/A Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Flintstone Allegany MD	
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR JAN 8 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>	

8701 1000 21018

Handwritten notes at the bottom left, including "8701" and "21018".

031038

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT LEE MEYERS			2a. DATE OF DEATH MONTH DAY YEAR January 18, 1986		2b. HOUR 12:00noon M	
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 06-30-1907		
6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.						
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hosp. & Medical Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		
12b KIND OF BUSINESS OR INDUSTRY railroad						
13a. STATE MD			13b. COUNTY Allegany			
13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS / ZIP CODE 104 Blackiston Avenue/21502						
14 FATHER'S NAME FIRST MIDDLE LAST George Henry Meyers			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie Rebecca Burkhart			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. 705-07-9683		17. INFORMANT ADDRESS Mrs. Bertha M. Meyers, Cumberland, MD - wife		
18 CAUSE OF DEATH - Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Indel @ VA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Pneumonia						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I (this hospital) attended the deceased from above, (I (we) (did) (did not) view the body after death. 19 86/10/1 to 1/18/86 , that (I (we) last saw the deceased alive on 1/18/86 and that in (my (our) opinion death occurred on the date and hour and from the causes stated						
22b. SIGNATURE Shen A. Nail		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. James Raver		22e. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 01-21-1986		23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD						
24 FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR IAN 27 1986		25b. REGISTRAR'S SIGNATURE Shen A. Nail		

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or either of these items is marked, the medical examiner must be notified and a medical investigation conducted.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

030180



AMERICAN
RED
CROSS

100% COTTON FIBER



036047

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 50M 4/83
(VRA 15, 4)

GEORGE UPCHURCH FUNERAL HOME
FOR GREEN STREET
STATE REGISTRAR CUMBERLAND, MD 21502
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

000067

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALTHERNE LYNN MORGAN			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 30, 1986		2b. HOUR 6:15 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 26, 1911			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH AK ALLEGANY COUNTY MD.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Food Svc-Allegany Bd. of Ed.			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 709 Ridge Terrace / 21502				
14. FATHER'S NAME FIRST MIDDLE LAST John P. Smarr			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma - Teauton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS John Morgan 701 McKinley Ave. Cumberland, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Lung Disease DUE TO, OR AS A CONSEQUENCE OF (c) years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Pulmonary Emboli Congestive Heart Failure							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Victor Mazzocco M.D.				DEGREE M.D.		22c. DATE SIGNED 1-30-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Victor Mazzocco, M.D.				22e. ADDRESS BMG 912 SETON DRIVE, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-1-86		23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Meml. Gdns.		23d. LOCATION CITY OR TOWN COUNTY STATE LaVale-Allegany Co.-Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS George-Upchurch Funeral home, P.A. 202 Greene Street-Cumberland, Maryland 21502				25a. DATE REC'D. BY REGISTRAR FEB 03 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

030071

ALTHEA LINE ACTION JANUARY 20, 1986 8:12 A

IN ALLEGANY COUNTY

SACRED HEART HOSPITAL



END 212 STION DRIVE, CUMBERLAND, W.D. 21502

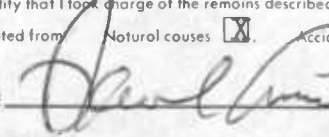
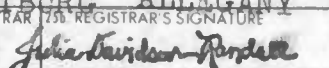
FEB 03 1986

020334

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00068

1. DECEASED NAME (TYPE OR PRINT) FREDA L. MORGAN										2a. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input checked="" type="checkbox"/> 1/6 1986				2b. HOUR <input type="checkbox"/> MIN <input type="checkbox"/> SEC <input type="checkbox"/> 8:30 PM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 7 DAY 22 YEAR 07		6. AGE (IN YEARS) LAST BIRTHDAY 78 YRS		IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>		7c. DATE PRONOUNCED DEAD MONTH 1 DAY 6 YEAR 1986		8. HOURS 8:45 PM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD					
10. CITY OR TOWN OF DEATH NATIONAL				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RT. 1, FROSTBURG				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CAFETERIA				12b. KIND OF BUSINESS OR INDUSTRY COLLEGE					
13a. STATE MARYLAND										13b. COUNTY ALLEGANY		13c. CITY OR TOWN NATIONAL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RT. 1 FROSTBURG	
14. FATHER'S NAME FIRST RUSSELL MIDDLE LEADER LAST EDITH				15. MOTHER'S MAIDEN NAME FIRST EDITH MIDDLE BLACK LAST BLACK				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) N.A.									
16b. SOCIAL SECURITY NO.				17. INFORMANT RUSSELL MORGAN, BARTON, MD													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) HYPERTENSIVE CARDIOVASCULAR HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) YEARS														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE 				TITLE (SPECIFY) DEPUTY				MEDICAL EXAMINER				DATE SIGNED 1/6/86					
EXAMINER'S NAME (TYPE OR PRINT) PAUL SNOW, M.D.				ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1/9/86				23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK FROSTBURG ALLEGANY MD				23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR SOWERS FUNERAL HOME				ADDRESS 60 W. MAIN ST. FROSTBURG				25a. DATE REC'D. BY REGISTRAR JAN 13 1986									
25b. REGISTRAR'S SIGNATURE 																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM, PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFER CARD. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

042076

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN FRANCIS MULLAN			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 31, 1986		2b. HOUR 0433 A M
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 11-08-1917	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired	12b. KIND OF BUSINESS OR INDUSTRY textile	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Allegany 13c. CITY OR TOWN Flintstone			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John Leo Mullan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary A. Eirich		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 217-10-6892	17. INFORMANT ADDRESS Mrs. Mary J. Mullan, Flintstone, MD - wife			
18. CAUSE OF DEATH (Enter only one cause per line for immediate cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiomyopathy, MI, Cardiogenic shock</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>MI, Cardiogenic shock</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>MI</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>COOP</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital is the place where the deceased died on <i>Jan 30, 1986</i> and that (2) (we) lost <i>Jan 31, 1986</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE <i>Terry Williams</i>	DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>2-3-86</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. TERRY WILLIAMS		22e. ADDRESS MEDICAL BUILDING MEMORIAL HOSPITAL, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 02-03-1986	23c. NAME OF CEMETERY OR CREMATORY SS Peter Paul Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR <i>FEB 05 1986</i> 25b. REGISTRAR'S SIGNATURE <i>John Davidson-Russell</i>			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 is not any injury, or other traumatic event, the medical examiner will be notified.

QUICK FIBERS

DOWN

NEW



016004

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items 18-22a 3/21/86 mtb F#613										STATE OF MARYLAND											
FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOUISE W. MURPHY										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 1-6-86 19											
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 07-15-1913		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 72		IF UNDER 1 YR. MONTHS DAYS 0 0		IF UNDER 24 HRS. HOURS MIN 0 0		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-6-86 19									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD										7b. CITIZEN OF WHAT COUNTRY? USA											
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD											
10. CITY OR TOWN OF DEATH Cumberland										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) Memorial Hospital											
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) cashier										12b. KIND OF BUSINESS OR INDUSTRY market											
13a. STATE MD										13b. COUNTY Allegany											
13c. CITY OR TOWN Cumberland										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
13e. STREET ADDRESS 703 Frederick Street/21502																					
14. FATHER'S NAME FIRST MIDDLE LAST Dennis Ambrose Murphy										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Dreyer											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no										16b. SOCIAL SECURITY NO. 217-10-7901											
17. INFORMANT ADDRESS Anna C. Clipp, Baltimore, MD - sister																					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries to brain with old infarcts of DUE TO, OR AS A CONSEQUENCE OF cerebellum and brain (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																					
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 5:00 P.M. 1/5 1986											
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject fell																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)											
21f. LOCATION STREET CITY OR TOWN COUNTY STATE																					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE Margarita A. Korell										TITLE (SPECIFY) Assistant MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.										ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 1-10-1986											
23c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery										23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD											
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502										25. DATE RECEIVED BY REGISTRAR JAN 13 1986											

07/84
25MDHMM - 17
(VR A15 ME (5))

UNITED

FROM COLUMBIA LIDEN
UNITED STATES POST
CHIEF MAIL
UNITED STATES



1870

020063

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

HAFER FUNERAL HOME
LAVALE, MD
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

00071

 FOR
 1- STATE
 REGISTRAR

21502

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALBINO J NICOLATO, SR			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 9, 1986			2b. HOUR 8:25 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 31, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Groundsman		12b. KIND OF BUSINESS OR INDUSTRY Hospital		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Rawlings		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Route 3, Box 303 / 21557		
14. FATHER'S NAME FIRST MIDDLE LAST Geralamo Nicolato			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carlina Fongaro							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-24-8365		17. INFORMANT ADDRESS Albino J. Nicolato, Jr. - same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Head trauma Congestive Heart Failure										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from JAN 5, 1986, to JAN 9, 1986, that (I) (we) lost saw the deceased alive on JAN 9, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22a. SIGNATURE Paul J. Livengood MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-12-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Livengood MD						22e. ADDRESS BMG 912 SETON DRIVE, CUMBERLAND, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SEE IF 1) Burial			23b. DATE 1/11/86		23c. NAME OF CEMETERY OR CREMATORY St. Michael's Cem. Frostburg, Alleg., MD			23d. LOCATION CITY OR TOWN COUNTY STATE Frostburg Allegany MD		
24. FUNERAL DIRECTOR NAME ADDRESS John J. Hafer, Jr. LaVale, MD 21502										
25a. DATE REC'D. BY REGISTRAR JAN 16 1986						25b. REGISTRAR'S SIGNATURE				

MEDICAL CERTIFICATION

BP

020063

21202

LAVALE, MD

HATER BUREAU HOME

ALBINO

NICOLATO, JR

JANUARY 2, 1946

6:12 A

Male

White

Aug. 24, 1897

CA

Italy

USA

X

ALBINO CITY

Cambridge

SACRED HEART HOSPITAL

Heardman

Hospital

Cambridge

Lawrence

Box 507, 11257

Getelamo

Nicolaso

Arline

Arline

No

212-24-8365

Albino J. Nicolato, Jr. - same as above

Paul Laverne

ONE SIX SEVEN DRIVE, CUMBERLAND, MD 21502

1/11/58

Enlight

1/11/58

John J. Ratt, Jr., 1-Val, MD 21502

028165

Sowers Funeral Home			STATE OF MARYLAND			86 00072		
1- FOR STATE REGISTRAR			60 West Main Street Frostburg, MD 21532			DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Harry Clarence Ort			January 18, 1986			11:35PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
MALE	WHITE	1/13/08	78 YRS.			IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND	U.S.A.		Allegany County, MD					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND	Sacred Heart Hospital	MASTER BAKER	BAKERY					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
MARYLAND			ALLEGANY			FROSTBURG		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
CLARENCE ORT			MARGARET Mac FARLAND					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
NO			N.A.			213016094		
			ADDRESS			72 WASHINGTON ST., FROSTBURG, MD, 21532		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>								
912 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
(b) <u>Aspiration</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c) <u>Lung Abscess</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
<u>Chronic obstructive lung disease, etc.</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
			HOUR A.M. MONTH DAY YEAR					
			P.M. 19					
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE						DEGREE		22c. DATE SIGNED
<u>Clarence Vincent, M.D.</u>						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS		
Clarence Vincent, M.D.						909-B Seton Drive, Cumberland, MD 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
CREMATION			1/20/86		SMITHBURG CREMATORIUM		SMITHBURG MD.	
24. FUNERAL DIRECTOR			SOWERS FUNERAL HOME			25a. DATE REC'D BY REGISTRAR		
NAME			60 W. MAIN ST. FROSTBURG			25b. REGISTRAR'S SIGNATURE		
<u>Wm. M. Sowers</u>						<u>John Davidson-Rodell</u>		

0621 81 1111

50

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

VIII

Allison County

Individualized Instruction

520810615

2025 RELEASE UNDER E.O. 14176

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

020058

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HAZEL LORRAINE POLING			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 7, 1986		2b. HOUR 11:30 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 8 1909		
6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS		12b. KIND OF BUSINESS OR INDUSTRY -----				
13a. STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		
14. FATHER'S NAME FIRST MIDDLE LAST LEMUEL L COMBS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE ORNDORFF		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-12-3315		17. INFORMANT ADDRESS Mrs WILLIS ROBERTSON RFD#5 BOX 320 CUMBERLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gram negative sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Septic</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <i>4 days</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>4 days</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>0</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (if this hospital) attended the deceased from <i>1/2/86</i> to <i>1/8/86</i> that (we) last saw the deceased alive at (above) (1) (we) did (did not) view the body after death. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.						
22b. SIGNATURE <i>W. Guy Fiscus</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/8/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. GUY FISCUS		22e. MEMORIAL HOSPITAL CUMBERLAND, MARYLAND		22f. MEDICAL BUILDING 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN 10 1986		23c. NAME OF CEMETERY OR CREMATORY REST LAWN CEMETERY		
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARY		23d. LOCATION CITY OR TOWN COUNTY STATE LAVALE ALLEGANY MARYLAND		25a. DATE REC'D. BY REGISTRAR JAN 13 1986		
				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodriguez</i>		

050028

20% CILION BEEK

WIN

20%



IN FANCY

031017

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EDNA PEARL RALSTON			2a. DATE OF DEATH MONTH DAY YEAR January 19, 1986			2b. HOUR 11:15a.m.				
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 05-16-1917		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital & Med. Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home		
13a. STATE MD			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12 West First Street/21502	
14. FATHER'S NAME FIRST MIDDLE LAST Riley Robertson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (nmn)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-54-8156		17. INFORMANT ADDRESS Ronney & Glendon Ralston - sons						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>asystole</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>ASCVD E CAD & CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>100m</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>12/27</u> 19 <u>86</u> , to <u>1/17</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1/17/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>T. Elder</u>						DEGREE <u>MD</u>		22c. DATE SIGNED 1/20/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. T. Elder
22e. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 01-21-1986		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502						25a. DATE REC'D. BY REGISTRAR JAN 27 1986				
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>										

MEDICAL CERTIFICATION

010100



Handwritten text at the bottom left corner, possibly a date or reference number.

029040

1- FOR
STATE
REGISTRARTIGHT FUNERAL HOME
309 DECATUR STREET
Cumberland, MD 21502STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (Type or Print) FIRST MIDDLE LAST Lenora A. Ready			2a. DATE OF DEATH MONTH DAY YEAR January 24, 1986		2b. HOUR 3:25A M	
3. SEX Female		4. RACE USA White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 29, 1897		
6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD		10. CITY OR TOWN OF DEATH Cumberland		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Operator Tire Co.		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		
13d. INSIDE CITY LIMITS? xx YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 604 A Frederick St. 21502		14. FATHER'S NAME FIRST MIDDLE LAST Michael Ready		
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Lynch		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-07-0400		
17. INFORMANT Edward Mattingly, Sr.		ADDRESS Cumberland, MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1985		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Partial amputation						
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N/A		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A		22a. I certify that (1) (this hospital) attended the deceased from Jan 24, 1986 to Jan 24, 1986 , that (we) lost saw the deceased alive on Jan 24, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death				
22b. SIGNATURE Bruce Behounek		DEGREE M.D.		22c. DATE SIGNED 1/24/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce Behounek, M.D.		22e. ADDRESS BMG, 912 Seton Drive, Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 27, 1986		23c. NAME OF CEMETERY OR CREMATORY St. Particks Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Savage Allegany MD		24. FUNERAL DIRECTOR NAME ADDRESS William G. Kight Cumberland, MD		25a. DATE REC'D. BY REGISTRAR JAN 27 1986		
25b. REGISTRAR'S SIGNATURE						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 472 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page 3.

050040

88	29pt. 29, 1897	USA	Female
88	29pt. 29, 1897	USA	Male
604 A Frederick St. 21502	Telephone Operator Tire Co.	Cumberland	MD
214-07-0400 Edward Harting, Jr.	Michael	Ready	MD
Cumberland, MD	Anna	Lynch	MD

William G. Knight Cumberland, MD
 Jan. 27, 1982. Partick's Cem. Mt. Savage Allegany MD
 Burial

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

024204

1. DECEASED NAME (TYPE OR PRINT) Robert W. Resser			2a. DATE OF DEATH MONTH DAY YEAR 01 10 86			2b. HOUR 8:30 P	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2 18 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD			
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lions Manor Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 235 Paca Street 21502		
14. FATHER'S NAME FIRST MIDDLE LAST George M. Resser		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Jacobs		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes Unknown			
16b. SOCIAL SECURITY NO. 188-03-7287		17. INFORMANT ADDRESS Anna M. Resser, 235 Paca St., Cumberland MD					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Severe C.H.F.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

A.S.C.V.D.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Chronic renal failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-31 , 19 85 , to 1-10 , 19 86 that (I) (we) lost saw the deceased alive on 1-10 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death			
22b. SIGNATURE V.A. Ranjithan	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 1-13-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. A. Ranjithan, M. D.		22e. ADDRESS LMNH, Seton Drive, Cumberland, MD 21502	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/14/1986	23c. NAME OF CEMETERY OR CREMATORY Susquehanna Memorial Gardens	23d. LOCATION CITY OR TOWN COUNTY STATE York Twp. York PA
24. FUNERAL DIRECTOR NAME Burg Funeral Home, Inc., 134 W. Broadway, Red Lion, Pa		25. REGISTRAR'S SIGNATURE John Anderson	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.)

103750



REV 8/11/14

020059

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGES FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH 17
(VR A15 ME (5))
20M 4/82

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00077

1. DECEASED NAME (TYPE OR PRINT)		FIRST MARY		MIDDLE Ethel		LAST Rose		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH DAY YEAR		1 7 1986		2b. HOUR		2:20 PM	
3. SEX		female		4. RACE		white		5. DATE OF BIRTH		MONTH DAY YEAR		09-13-1894		6. AGE (IN YEARS)		LAST BIRTHDAY		91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		PA		7b. CITIZEN OF WHAT COUNTRY?		USA		8. MARRIED		NEVER MARRIED		<input checked="" type="checkbox"/>		WIDOWED		DIVORCED		<input type="checkbox"/>	
10. CITY OR TOWN OF DEATH		Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		Sacred Heart Hospital (DOA)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		ret. teacher		12b. KIND OF BUSINESS OR INDUSTRY		Bd of Education					
13a. STATE		MD		13b. COUNTY		Allegany		13c. CITY OR TOWN		Cumberland		13d. INSIDE CITY LIMITS?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		301 Baltimore Street/21502	
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST					
		Ross		Rose						Mary		Heming							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		no		16b. SOCIAL SECURITY NO.		213-18-2496		17. INFORMANT		ADDRESS		Sister Rosemary VanAusdale							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: <u>Disease</u> (b) <u>Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Disease</u>																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE		Francisco Reyes		TITLE (SPECIFY)		Deputy		M.D.		MEDICAL EXAMINER		DATE SIGNED		1-7-87					
EXAMINER'S NAME (TYPE OR PRINT)		Francisco Reyes		ADDRESS		900 Seton Dr. Cumberland Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		Burial		23b. DATE		01-09-1986		23c. NAME OF CEMETERY OR CREMATORY		SS Peter Paul Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE		Cumberland Allegany MD					
24. FUNERAL DIRECTOR		NAME		ADDRESS		James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR		JAN 13 1986		25b. REGISTRAR'S SIGNATURE		John Davidson-Rodale					

050030

REF ID: A66030



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00078

020235

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE ESTIMATED			2c. DATE PRONOUNCED DEAD		
FIRST MIDDLE LAST Emel Joseph Rosenberga			MONTH DAY YEAR 1 2 1986			MONTH DAY YEAR 1 2 1986			2d. HOUR 12:36 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS				
M	W	Dec 1 1908	77 YRS.		MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH		
35 MARYLAND			U.S.A.			NEVER MARRIED			ALLEGANY MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY		
50 Cumberland			D.O.A. MEMORIAL HOSPITAL			CARTENTER BUILDING					
13a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN			13d. STREET ADDRESS		
3 MARYLAND			GARRETT			FROSTBURG			RT. 2, Box 426, 21532		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
110 CLARENCE ROSENBERGER			FLORENCE WARNER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
YES			W-W-2			216-18-1761			EDNA ROSENBERGER, 13E		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease,											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) Probably stroke.											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
									YES NO X		
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED					
			HOUR A.M. MONTH DAY YEAR			ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2					
21d. INJURY OCCURRED WHILE AT WORK			21e. PLACE OF INJURY			21f. LOCATION					
NOT WHILE AT WORK			STREET, FACTORY, FARM, ETC.)			CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner											
22b. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner											
ACTUAL SIGNATURE			TITLE (SPECIFY)			MEDICAL EXAMINER			DATE SIGNED		
Francisco Reyes			M.D. Deputy						1-2-86		
EXAMINER'S NAME			ADDRESS								
(TYPE OR PRINT)			Francisco Reyes			900 Seton Dr. Cumberland, Md. 21502					
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		
BURIAL			JAN 5, 1986			GREENVILLE CEMETERY			FOCAMONTAS, PA.		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
DURST FUNERAL HOME, FROSTBURG, MD.			JAN 13 1986			Julia Swinton Riddle					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALSO RETURN WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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25M

BP
DHMH - 17
(VR A15 ME (5))

ES2020

DOWN

WATER



WATER & CO. 1880

~~1. FOR
STATE
REGISTRAR~~

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		A	
Elizabeth		H.		Rosenmerkel				01		16	1986	2:15				M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.						
female		caus		04 MONTH 01 DAY 1900		85 YRS.		MONTHS		DAYS		HOURS		MIN.		
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										MD
MD		USA				Allegany										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY										
Cumberland		Lions Manor Nursing Home		Ret. Nurse		County Govern										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE								
MD		Allegany		Cyberland				708 Shriver Ave. 21502								
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)														
Unknown		Dodd		Unknown		Unknown										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS										
No		218-38-2318		Diana Roberts		Frederick, MD										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		Cerebrovascular accident.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF		Atrial fibrillation.												
		DUE TO, OR AS A CONSEQUENCE OF		Anteriosclerotic heart disease												
		(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		Chronic brain syndrome														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from 10-9, 1979, to 1-16, 1986, that (I) (we) last saw the deceased alive on 1-13, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE V.A. Raghithan		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 01-16-86										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Vinala Raghithan		22e. ADDRESS Lions Manor Nursing Home, Cumberland, Md														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE										
Burial		Jan. 18, 1986		Rose Hill Cemetery		Cumberland Allegany MD										
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE												
William G. Kight Cumberland, MD		JAN 23 1986		[Signature]												

30% Cotton Fibers

MD

USA

x

Ref. Nurse

County Govern

MD

Allegheny

Cumberland

xx

708 Shriver Ave. 21502

Unknown

Dodd

Unknown

Unknown

No

218-38-2318 Diana Roberts Frederick, MD



Burial

Jan. 18, 1980 One Hill Cemetery Cumberland Allegheny MD

William G. Right Cumberland, MD

027044

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified of this.

MARKWOOD FUNERAL HOME STATE OF MARYLAND
11 MINERAL STREET DEPARTMENT OF HEALTH AND MENTAL HYGIENE
KEYSER, WVA 26726 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NORRIS COLLINS SCHADE			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 20, 1986			2b. HOUR 1:15 P.M.						
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 9 1908		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.						
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Electrician Westvaco		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE W.Va.		13b. COUNTY Mineral		13c. CITY OR TOWN Keyser		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 416 South Main St. 99999				
14. FATHER'S NAME FIRST MIDDLE LAST Tarson H. Schade				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Bell Grandstaff								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-07-6022		17. INFORMANT Mr. Hollis L. Schade				ADDRESS LaVale, Md. 21502				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cor. Art. Dis.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>A. S. C. V. D.</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> 19 <u>86</u> to <u>1/20</u> 19 <u>86</u> that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>C. Vincent</u>						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CLARENCE VINCENT, MD						22e. ADDRESS 909-B SETON DRIVE, CUMBERLAND, MD 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 23, 1986		23c. NAME OF CEMETERY OR CREMATORY Potomac Mem. Gardens			23d. LOCATION CITY OR TOWN COUNTY STATE Keyser Mineral W.Va.				
24. FUNERAL DIRECTOR <u>E. McKenzie</u>						ADDRESS Box 912		25a. DATE REC'D. BY REGISTRAR JAN 23 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		
Markwood-McKenzie Funeral Home, Keyser, W.Va.												

11 MINERAL STREET
KEYSER, WVA 26726

MOORE COLLINS SCHWARTZ

WINTERWAY CO, 1986

ALLEGANY COUNTY

SACRED HEART HOSPITAL

CLARENCE VINCENT, MD
202-B SETON DRIVE, CLARENDON, MD 21702

CLARENCE VINCENT, MD
202-B SETON DRIVE, CLARENDON, MD 21702

041006

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ISAAC JACOB SHOBE			2a DATE OF DEATH MONTH DAY YEAR January 18, 1986		2b HOUR 12:08p.m.
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 11, 1916		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.Va.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10 CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital & Med Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	12b KIND OF BUSINESS OR INDUSTRY Gen. Farming	
13a STATE W.Va.			13b COUNTY Grant	13c CITY OR TOWN Dorcas	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Isaac Shobe			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Bergdoll		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 215-18-1604	17 INFORMANT ADDRESS Wilson Shobe Gen. Del. Dorcas, W.Va.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive Brain Stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Kheder Ashker		DEGREE MD.		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. A. Figueroa		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22e ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE Jan 21, 1986	23c NAME OF CEMETERY OR CREMATORY Shobe Fam. Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Dorcas, W.Va. Grant County		
24 FUNERAL DIRECTOR NAME Arnold-Basagic Funeral Home Petersburg, W.Va.		25 DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE JAN 31 1986 [Signature]			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove this page. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

041006

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100% COTTON FIBER

042010

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 00082

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
ROBERT TAYLOR SHROUT SR						JANUARY 29, 1986			11:59 ^{AM}		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male		White		MONTH DAY YEAR Apr 11 1913			72 YRS			MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
WV			U.S.A.						ALLEGANY COUNTY MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Cumberland			SACRED HEART HOSPITAL						Retired Mechanic		
12b. KIND OF BUSINESS OR INDUSTRY			Auto Industry								
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
WV			Mineral		Keyser		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt 2 Box 107 26726		
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Balford T ShROUT						Lilea Grapes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Yes			WW II			212-12-8383			Marie Lee ShROUT Rt 2 Box 107 Keyser, WV 26726		
18. CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF											30 min
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											15 days
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a											
PULMONARY FIBROSIS											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 11</u> , 19 <u>86</u> , to <u>JAN 29</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>JAN 29</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
<u>Paul Livengood MD</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			1-30-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Paul Livengood, MD						BMG 912 SETON DRIVE, CUMBERLAND, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			2/1/86		Potomac Mem. Garens			Keyser Mineral WV			
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
A. Craig Rotruck 85 S Main St Keyser, WV 26726						FEB 05 1986			<u>John Davidson-Randall</u>		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers (pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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11:50 P

QUARTY 12, 1966

STREET 27

TAYLOR

ROBERT

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STATE

FILE

ALLEGANY COUNTY

SACRED HEART HOSPITAL

CHANDLER

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified of the death.

EICHORN FUNERAL HOME 1- STATE MAIN STREET REGISTRAR LONA CONING, MD. 21562				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT) NAIDENE WILCOX SIGLER				2a. DATE OF DEATH MONTH DAY YEAR JANUARY 27, 1986				
3. SEX Female				4. RACE White		5. DATE OF BIRTH Feb. 8, 1905		
7a. BIRTHPLACE (STATE OR FOREIGN) W.Va.				7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 80		
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
13a. STATE Md				13b. COUNTY Allegany		13c. CITY OR TOWN Lonaconing		
14. FATHER'S NAME FIRST A. MIDDLE Wilcox LAST				15. MOTHER'S MAIDEN NAME Lucy B. MIDDLE Neepor LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None				16b. SOCIAL SECURITY NO. 214-04-6240		17. INFORMANT Helen L. Buser, Rt. 2, Box 487, Ridgeley, W.Va. 26753		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chronic pulmonary arrest</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Day		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary artery dis</i>						DUE TO, OR AS A CONSEQUENCE OF 1 Year		
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Paul Livengood</i> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-28-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL LIVENGOD, M.D.				22e. ADDRESS BMG, 912 SETON DRIVE, CUMBERLAND, MD. 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-30-86		23c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park		23d. LOCATION Cumberland Allegany Md.		
24. Eichorn Funeral Home, Lonaconing, Md.				25a. DATE REC'D. BY REGISTRAR JAN 31 1986		25b. REGISTRAR'S SIGNATURE <i>Gene Davidson-Randall</i>		

BP

0351-11

EICHORN FUNERAL HOME
MAIN STREET
LIMONING, N. J. 07036

WIDOWE ALICE SISTER JANUARY 27, 1922 1:02PM

SALE Feb. 5, 1952

ALLEGANY COUNTY

SACRED HEART HOSPITAL

CHURCH

ALLEGANY COUNTY LONACONING, N. J. 07036

WIDOWE ALICE SISTER JANUARY 27, 1922 1:02PM

WIDOWE ALICE SISTER JANUARY 27, 1922 1:02PM

PAUL LIVINGOOD, N.J. 07036

PAUL LIVINGOOD, N.J. 07036

PAUL LIVINGOOD, N.J. 07036

041036

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES RUSSELL SNYDER			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 27, 1986		2b. HOUR 7:35A M
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR 09/16/1918		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10 CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) machine operator		12b. KIND OF BUSINESS OR INDUSTRY quarry
13a. STATE PA	13b. COUNTY Bedford	13c. CITY OR TOWN Hyndman	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Cleveland St/ 15545 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Francis Joseph Snyder		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Beals			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII	17 INFORMANT ADDRESS Virginia Snyder, Box 68, Hyndman, PA 15545			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Legs lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pneumonia, Silicosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 1/27/86 to 1/27/86 that (we) last saw the deceased alive on 1/27/86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE Shawn Nalley		DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED 1/27/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. NATHAN		22e. HOSPITAL NAME MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 01/30/86	23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hyndman, Bedford, PA
24 FUNERAL HOME Harvey H. Zeigler, Hyndman, PA 15545			25. FEB 03 1986		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and completely fill in by the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

041036

100% COTTON

MADE IN U.S.A.



041036

036141

WILLIAM J. WOOD

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE REGISTRAR
FURNAL HOME
ROCKWOOD, PA

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Merle Ray Snyder			2a. DATE OF DEATH MONTH DAY YEAR 01 17 86		2b. HOUR 00:35a		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 6 16		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Building	
13a. STATE Pa		13b. COUNTY Somerset		13c. CITY OR TOWN Rockwood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Snyder		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SADIE ENOS Snyder		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes World War II		16b. SOCIAL SECURITY NO. 206033977/1	
17. INFORMANT Betty Snyder		18. ADDRESS RD2 Rockwood Pa.		19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cat all ca of the lung DUE TO, OR AS A CONSEQUENCE OF (b) with widespread metastasis DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-30 , 19 86 , to 1-17 , 19 86 , that (I) (we) last saw the deceased alive on 1-16 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. N. Mehanna		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-17-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. J. N. Mehanna		22e. ADDRESS 909-B Seton Drive, Cumberland, Md. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/20/86		23c. NAME OF CEMETERY OR CREMATORY Toof Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockwood Somerset Pa	
24. FUNERAL DIRECTOR NAME Francis Brody		ADDRESS 933 Branchburg Rockwood Pa		25a. DATE REC'D. BY REGISTRAR FEB 03 1986		25b. REGISTRAR'S SIGNATURE Gabe Davidson-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2, and send them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, then any injury, or other traumatic event, has occurred within 24 hours after death.

00111

WILLIAM V. MOOD
FURNERAL HOME, INC.
1000 1/2 E. 10th St.
Oklahoma City, Okla.

APR 14 1960

Alfalfa County

0000000000

000-B Soda Drive, Oklahoma City, Okla.

Dr. J. H. Johnson

023088

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
RUTH S SOLOMON				January 17, 1986		3:30 ^A M	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
Female	White	June 15, 1915		70 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	U.S.A.			Allegany MD			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland	Memorial Hospital		Homemaker		Home		
13a STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE		
Maryland		Allegany	Cumberland	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Cumb. Nurs. Home / 21502		
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		ADDRESS			
FIRST MIDDLE LAST		FIRST MIDDLE LAST					
Floyd - Stickley		Minnie Ferguson					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT			
No -		218-70-1297		Ethel Schramm - 25 E. Mary St., Cumberland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) DIABETES MELLITUS							
DUE TO, OR AS A CONSEQUENCE OF							
(c) HYPERTENSION							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
				M.D.		1/17/86	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS			
Dr. Susan Schwartz				Frostburg Plaza Frostburg, Md. 21532			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
Burial		1-20-86		Sunset Memorial Park		Cumberland-Allegany Co.-Md.	
24 FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George-Upchurch Funeral Home P.A. 202 Greene Street, Cumberland, Md. 21502				JAN 21 1986			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be retained by the funeral director. 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, state the injury, or other traumatic event, the medical examiner must be notified.

020630

JAN 21 1986

022081

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Layton H Stott			2a. DATE OF DEATH MONTH DAY YEAR 1 13 86		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6 5 21	6. AGE (IN YEARS LAST BIRTHDAY) 64	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD		
10. CITY OR TOWN OF DEATH Frostburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR	12b. KIND OF BUSINESS OR INDUSTRY CITY STREET DEPT.	
13a. STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Frostburg	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 183 Grant Street 21532
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT STOTT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELLIE PORTER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 212 18 1174	17. INFORMANT FROSTBURG, MD 21532 MRS. LAYTON STOTT, 83 GRANT ST.,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST. DUE TO, OR AS, A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS, A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug 19 83 to Jan 13 19 86 , that (I) (we) last saw the deceased alive on Nov 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S. Chang MD.		DEGREE MD.		22c. DATE SIGNED 1/13/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S. Chang		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) BURIAL		23b. DATE 1/15/86	23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM PK FROSTBURG		23d. LOCATION CITY OR TOWN COUNTY STATE ALLEGANY MD
24. FUNERAL DIRECTOR SOWERS FUNERAL HOME		ADDRESS W. MAIN ST. FROSTBURG		25a. DATE REC'D. BY REGISTRAR JAN 27 1986	
				25b. REGISTRAR'S SIGNATURE John A. B. [Signature]	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's papers. Pages 4 and 5 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, the death certificate must be filed with the coroner.

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LIBER



LIBRARY OF THE UNIVERSITY OF MICHIGAN

031023

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) George E. Thomas, Sr.			2a DATE OF DEATH MONTH DAY YEAR 1 21 86		2b HOUR 9:35 AM
3 SEX male	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR 09-28-1908		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10 CITY OR TOWN OF DEATH Frostburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Village Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ret. brakeman	12b KIND OF BUSINESS OR INDUSTRY railroad	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD 13b COUNTY Allegany 13c CITY OR TOWN Cumberland		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 220 Somerville Avenue/21502
---	--	--	--

14 FATHER'S NAME FIRST MIDDLE LAST Daniel Thomas		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delsie Moore	
--	--	---	--

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 232-26-0328	17 INFORMANT ADDRESS Mrs. Juanita V. Thomas, Cumberland, MD - wife
---	---	--

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Atherosclerosis</u>		years
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic obstructive lung disease, prior Cerebrovascular accident, atherosclerotic coronary disease.

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)
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21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE
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22a I certify that (I) (this hospital) attended the deceased from Aug 25, 19 85, to Jan 21, 19 86, that (I) (we) last saw the deceased alive on Jan 19, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did not) view the body after death.

22b SIGNATURE <u>Thomas J. Decker</u>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 1-21-86
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22d PHYSICIAN'S NAME (TYPE OR PRINT) Thomas J. Decker MD	22e ADDRESS 55 Jackson St., Dorchester, MA.
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23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 01-24-1986	23c NAME OF CEMETERY OR CREMATORY Levels Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Levels Hampshire WV
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24 FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502	25a DATE REC'D. BY REGISTRAR JAN 27 1986	25b REGISTRAR'S SIGNATURE <u>Julia Davidson-Pondale</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low temperature of the body at the time of death is to be recorded on the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should file this certificate with the State Dept. of Health and Mental Hygiene prior to removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

031010

100% COTTON FIBER

WOLMAN FIBER

036051

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 00089

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PAULINE WYOMIA THOMPSON			2a. DATE OF DEATH MONTH DAY YEAR Jan. 26, 1986		2b. HOUR MIN. 7:34 a
3. SEX Female	4. RACE White-Cau.	5. DATE OF BIRTH MONTH DAY YEAR 12 5 18		6. AGE (IN YEARS LAST BIRTHDAY) 67	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.VA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE MD.		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 619 Baker Street 21502
14. FATHER'S NAME FIRST MIDDLE LAST James E. Moats		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Chloe Lease			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-80-6439		17. INFORMANT ADDRESS R# 1 Box 59 Charles St. LaVale, Md. 21502	

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Heart myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

(c) Adv. Arteriosclerosis

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1987</u> to <u>1-26</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>1-26</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>William P. James</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>1/27/86</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William James		22e. ADDRESS 441 N. Centre St., Cumberland, Md. 21502	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-29-86	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany Md.
24. FUNERAL DIRECTOR NAME Silcox-Merritt 404 Decatur St., Cumb., Md.		25a. DATE REC'D. BY REGISTRAR JAN 30 1986	25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21202

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



042085

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Raymond Edward Thompson			2a. DATE OF DEATH MONTH DAY YEAR 1 28 86		2b. HOUR 12:55 PM
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 08-27-1891		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Frostburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Village Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired	12b. KIND OF BUSINESS OR INDUSTRY Plumbing	
13a. STATE MD			13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William E. Thompson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Liebrandt		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-10-6541	17. INFORMANT ADDRESS Mr. Vincent M. Thompson, Mt. Savage, MD			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I: DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Carcinoma lung

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 months

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Dean	DEGREE MD	22c. DATE SIGNED 1-28-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Breza, M.D.		22e. ADDRESS 912 Seton Drive, Cumberland, MD 21502	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 01-31-1986	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR FEB 03 1986	
		25b. REGISTRAR'S SIGNATURE James F. Scarpelli	

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20% COTTON FIBER

WILSON & WILSON

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) JANET MARIE THRASHER			2a DATE OF DEATH MONTH DAY YEAR January 23, 1986		2b HOUR 9:27 PM
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 31, 1935		6 AGE (IN YEARS LAST BIRTHDAY) 50 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10 CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b KIND OF BUSINESS OR INDUSTRY Own Home	
13a STATE Md.			13b COUNTY Allegany	13c CITY OR TOWN Cumberland	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Mack --- Shoop			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn --- Cheshire		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) None		17 INFORMANT ADDRESS Cumberland, Md.	
		218 30 0154		Mr. Gordon Thrasher Jr. 519 Caroline Street	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Massive Myocardial Infarct</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Tobacco Abuse.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: o

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>Ranjithan</i>		DEGREE MD		22c DATE SIGNED 1/24/86	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ranjithan		22e ADDRESS 500 Memorial Ave., Memorial Med. Bldg. Cumberland, MD 21502			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 1/26/86	23c NAME OF CEMETERY OR CREMATORY Queens Point Cem.	23d LOCATION CITY OR TOWN COUNTY STATE Keyser Mineral W. Va.
24 FUNERAL DIRECTOR Harold W. McKenzie Harwood McKenzie Funeral Home, Keyser, W. Va.		25a DATE REC'D. BY REGISTRAR JAN 20 1986	25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Finger and 2 should be filed with 272 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

Copy of
Letter from
[illegible]

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1/11/11

022125

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			7b. HOUR		
JOHN DAVID TIMBROOK			JANUARY 12, 1986			10:30A		
3. SEX MALE			4. RACE CAUCASIAN			5. DATE OF BIRTH		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.			7b. CITIZEN OF WHAT COUNTRY? USA			8. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		
13a. STATE PA			13b. COUNTY SOMERSET			13c. CITY OR TOWN HYNDMAN		
14. FATHER'S NAME FIRST MIDDLE LAST PHILLIP TIMBROOK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE LOY			16. SOCIAL SECURITY NO. 232-26-0382		
17. INFORMANT ADDRESS DOROTHY BRYANT, BOX 374, RD, HYNDMAN, PA 15545			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic myeloid Leukemia</i> DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (I) did not view the body after death.								
22b. SIGNATURE <i>[Signature]</i>			DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/12/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Zaman			22e. ADDRESS Memorial Hospital Medical Bldg Cumberland, Maryland 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1/15/86		23c. NAME OF CEMETERY OR CREMATORY COMPS CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE RD HYNDMAN, SOMERSET, PA	
24. FUNERAL HOME HARVEY H. ZEIGLER, HYNDMAN, PA 15545			25a. DATE REC'D. BY REGISTRAR JAN 16 1986			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 50M 7/84
(VRA 15, 4)

first principle - when
independence is not

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028174

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1. DECEASED NAME (TYPE OR PRINT) MILDRED A. TROUTMAN			2a. DATE OF DEATH January 17, 1986		2b. HOUR 7:05 ^A M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH 07/14/20	6. AGE (IN YEARS LAST BIRTHDAY) 65	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	9. CITIZEN OF WHAT COUNTRY? USA	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD		
12. CITY OR TOWN OF DEATH Cumberland	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		15. KIND OF BUSINESS OR INDUSTRY
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE PA 16b. COUNTY Somerset 16c. CITY OR TOWN Hyndman	17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. STREET ADDRESS / ZIP CODE R D 1/15545 Southampton Twp		
19. FATHER'S NAME FIRST Jacob MIDDLE Bridges LAST		20. MOTHER'S MAIDEN NAME FIRST Frances MIDDLE Blucker LAST			
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	22. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 184-42-6094	23. INFORMANT ADDRESS Richard Troutman, R D 1, Hyndman, PA 15545			
24. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>Brain Stem Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
25. DATE OF OPERATION	26. CONDITION FOR WHICH OPERATION WAS PERFORMED	27. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
32. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	34. LOCATION STREET CITY OR TOWN COUNTY STATE			
35. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes noted above.					
36. SIGNATURE <u>[Signature]</u>		37. DEGREE MD	38. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		39. DATE SIGNED 1/18/86
40. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Zaman		41. ADDRESS Medical Building Memorial Hospital Cumberland, Md. 21502			
42. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	43. DATE 1/20/86	44. NAME OF CEMETERY OR CREMATORY Comps Cemetery	45. LOCATION CITY OR TOWN COUNTY STATE RD, Hyndman, Somerset, PA		
46. FUNERAL DIRECTOR NAME Harvey H. Zeigler, Hyndman, PA 15545		47. DATE REC'D. BY REGISTRAR 48. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84
(VRA 15, 4)

JAN 23 1986

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Lula B Truly			2a. DATE OF DEATH MONTH DAY YEAR 1/7/86			2b. HOUR 11:36a M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5/30/04		6. AGE (IN YEARS LAST BIRTHDAY) 81		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN) MD		7b. CITIZEN OF WHAT COUNTRY? United State		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Alleg. MD					
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital				12a. USUAL OCCUPATION (IF OTHER THAN WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland			13b. COUNTY Alleg		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Back ST, Midland, MD 21542		
14. FATHER'S NAME George			MIDDLE Miller		15. MOTHER'S MAIDEN NAME Victoria			MIDDLE Van Buskirk		Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none		17. INFORMANT Edward Truly			ADDRESS Rt 1, Box 524 Frostburg,			
18. CAUSE OF DEATH: Enter only one cause per line for 1a, 1b, and 1c. PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY ARTERY HEART DISEASE</u>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>DIABETES MELLITUS</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>H. Sidhu M.D.</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-7-86.			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. H. Sidhu						22e. ADDRESS Frostburg, MD					
23a. BURIAL, CREMATION, REMOVAL (S)			23b. DATE 1-9-86		23c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park			23d. LOCATION Cumberland Allegany Md.			
24. FUNERAL DIRECTOR NAME <u>Eichhorn Funeral Home</u>						ADDRESS Lonaconing MD		25a. DATE REC'D. BY REGISTRAR JAN 9 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

013007

Mr

Norman KAT

George

Miller

Victoria

Van Dusen

Edward Tully Rt 1, Box 524, Springfield, Md.

Tom

no



Serial 1-0-06 Sunset and Park Cumberland All-rany 10

013066

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00095

1- FOR STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
John R. Uhl Jr.		XX MONTH DAY YEAR 1 6 19 86	
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
Male	Cau	May 24 1904	81 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA	NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Allegany MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	108 Wilmont Ave.	Int. Rev. Service Gov.	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
Maryland	Allegany	Cumberland	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	
John Robert Uhl Sr.	Mary Carder	No	
16b. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
214-05-5778	Rose Uhl	PART I DEATH WAS CAUSED BY:	
	108 Wilmont Ave.	IMMEDIATE CAUSE (a) Cardiac arrest	
		DUE TO, OR AS A CONSEQUENCE OF	
		Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.	
		(b) Arteriosclerotic heart disease	
		DUE TO, OR AS A CONSEQUENCE OF	
		(c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?	
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. PLACE OF OCCURRENCE WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE		TITLE (SPECIFY)	
Paul Snow, M.D.		Dpty	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED	
Paul Snow, M.D.		1/6/86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	1-8-86	SS. Peter & Paul	Cumberland Allegany Md.
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Cumberland, Md. 21502	JAN 9 1986		
Leasure-Stein Inc. 230 Baltimore Ave.			

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ENCLOSURE ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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REBEL MOTION PICTURES

WINDY RIVER



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DIVISION OF VITAL RECORDS, 201 W. PLESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PLESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00096

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH DAY YEAR		7a. HOUR	
CHARLES		W.		VETTER				1-12-86 19				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		7d. HOUR	
male	white	11/14/1954		31 YRS.						1-12-86 19		12:15A	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7d. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
West Virginia		U.S.A.				Allegany County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Easton		Memorial Hospital		CARPENTER		Construction							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
W. Va.		HARDY		MOOREFIELD		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		TANNERY ROUTE 99499					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
MELTON RANDOLPH VETTER		MARTHA HEAVENER											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		216-66-2311		MARTHA Vetter - Moorefield, W Va									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Multiple injuries		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
7-8150				DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				(b)		DUE TO, OR AS A CONSEQUENCE OF							
				(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		driver of auto/fixed object collision							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		City or Town		County		State			
		unknown				Allegany Co., Maryland							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE		1-12-86		SIGNED			
Margaret A. Korell		Assistant											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn Street									
Margarita A. Korell, M.D.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE			
Burial		1/15/86		Olivet Cemetery		MOOREFIELD, W Va							
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
J. Thomas Fraley		- Moorefield, W Va				FEB 04 1986		John Davidson-Randall					

07/84
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(VR A15 ME (5))

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15 JUL 1964

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SECTION 202

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	MIN.
Stanley		W	Warne		1/	19/	86		7:12p	M
3 SEX	male	4 RACE	white	5. DATE OF BIRTH	MONTH	DAY	YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
				9/	11/	98		87		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH					
					Allegany Co MD					
10. CITY OR TOWN OF DEATH	Frostburg, Md	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
		Frostburg Community Hospital			Mechanic			Auto Co.		
13a. STATE	Maryland	13b. COUNTY	Allegany	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE				
						164 W. Main St., 21532				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST		FIRST MIDDLE LAST								
Daniel W. Warne		Margaret Humbertson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS						
No		216 01 8814		Mrs. Helen Chaney, La Vale, Maryland 21502						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Respiratory failure</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) <u>COPD & pulmonary hypertension</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>Congestive Heart failure</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
<u>Renal Failure</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
		HOUR A.M. MONTH DAY YEAR								
		P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION						
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>				CITY OR TOWN COUNTY STATE						
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										
22. I certify that (I) this hospital attended the deceased from <u>Jan 18</u> 19 <u>86</u> to <u>Jan 18</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>Jan 18</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22a. SIGNATURE				DEGREE				22c. DATE SIGNED		
<u>Charles W. Oh</u>				<u>MD</u>				<u>1/21/86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS						
Dr. C. Oh				48 Tarn Terrace, Frostburg, Md 21532						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION				
Burial		Jan. 22, 1986		St. Anns Cemetery		Avilton, Garrett, Md.				
24 FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
NAME ADDRESS				JAN 27 1986		<u>[Signature]</u>				
Durst Funeral Home, Frostburg, Md.										

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other event, the medical examiner must be notified.

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FOR STATE REGISTRAR
SHAFFERS FUNERAL HOME
 230 E. MAIN ST. ROMNEY WV
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

STATE OF MARYLAND

8 6

0 0 0 9 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES WESLEY WARNER SR.			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 18, 1986		2b. HOUR 7:45AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 15 1917		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor, Maint.		12b. KIND OF BUSINESS OR INDUSTRY School Dist.
13a. STATE WV			13b. COUNTY Hampshire	13c. CITY OR TOWN Levels	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Noah Warner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cordelia Pickett		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 236073297A		17. INFORMANT Colleene M. Warner ADDRESS Levels, WV 25431	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic ca of the liver DUE TO, OR AS A CONSEQUENCE OF: (b) to liver - mani - DUE TO, OR AS A CONSEQUENCE OF: (c) COPD with fracture.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-16-1986 to 1-18-1986 , that (I) (we) last saw the deceased alive on 1-17-1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John Mehan				DEGREE M.D.	22c. DATE SIGNED 1-20-86
22e. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MEHANNA, M.D.				22f. ADDRESS 909-B SETON DRIVE CUMBERLAND, MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/21/86	23c. NAME OF CEMETERY OR CREMATORY Levels Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Levels Hampshire WV	23e. DATE REC'D BY REGISTRAR JAN 27 1986	
24. FUNERAL DIRECTOR NAME Keith S. Shaffer			25. REGISTRAR'S SIGNATURE John Davidson		
Shaffer Funeral Home, Romney, WV 26757					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial/transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event (the medical examiner must be notified and a report filed at once).

031076

SHIPPERS FLORAL HOME
220 E. WALTON ST. ROYAL IN

CHARLES WERLEY FARMER

JANUARY 13, 1946

ALLEGANY COUNTY

SACRED HEART HOSPITAL



326073257A



900-A SEVEN DRIVE CINCINNATI, MO. 31502

JOHN HENRY, M.D.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and checked by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Paper must be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be called to the scene.

BP.

DHMH - 16 60M 7/B4
(VRA 15, 4)

FOR STATE REGISTRAR BOALS FUNERAL HOME 117 CHURCH ST. WESTERNPORT, MD 21158
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
MARTHA		LOUIS	WASHINGTON		JANUARY 4, 1986					9:30 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		7b. IF UNDER 24 HRS.	
Female		Black		6 MONTH 11 DAY 1904 YEAR		81		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
West Virginia		U.S.A.				ALLEGANY COUNTY		MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		SACRED HEART HOSPITAL				Domestic		House			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10 G Joke Frazier Village 21502			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Wm. FIRST MIDDLE LAST L Washington				Sarah FIRST MIDDLE LAST Belle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
no				235-74-1775		Mrs. Lorraine Kithcart Piedmont, W.Va.					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF 1b) <u>CARCINOMA OF LUNG</u> DUE TO, OR AS A CONSEQUENCE OF 1c) _____ Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day.</u> <u>6 months.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>11/4/86</u> to <u>1/4/86</u> , that (I) (we) last saw the deceased alive on <u>11/4/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Arvind Pathak</u>				DEGREE <u>MD</u>				22c. DATE SIGNED <u>1/5/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARVIND PATHAK, M.D.				22e. ADDRESS 913 SETON DRIVE CUMBERLAND, MD. 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		1/8/86		Potomac Memorial Gardens		Keyser Mineral W.Va.					
24. FUNERAL DIRECTOR NAME <u>Wayne Brath</u> ADDRESS <u>Westernport, Md. 21562</u>				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Jake Davidson</u>					
Boal Funeral Service				JAN 13 1986							

018002

114 CHURCH ST. WESTPORT, NY.
COUNTY OF WESTPORT

WASHINGTON

JANUARY 1, 1952

0:30 P

ALLEGANY COUNTY

SACRED HEART HOSPITAL

WESTPORT, NY.

10 E. 1st St. Westport, NY 12992

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ROTRUCK FUNERAL HOME

1- FOR 85 S. MAIN STREET
STATE REGISTRAR KEYSER, WV 26726STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES HERMAN WEBB			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 24, 1986			2b. HOUR 4:00 P.M.					
3. SEX Male		4. RACE Cau		5. DATE OF BIRTH MONTH DAY YEAR Oct 12 1938		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Computer Operator		12b. KIND OF BUSINESS OR INDUSTRY Westvaco Corp.					
13a. STATE WV			13b. COUNTY Mineral		13c. CITY OR TOWN Keyser		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 155 Baker Street 26728		
14. FATHER'S NAME FIRST MIDDLE LAST Herman L. Webb			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vivian T. Wood			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No --				16b. SOCIAL SECURITY NO. 232-62-7121	
17. INFORMANT ADDRESS Louise Webb 155 Baker St Keyser, WV 26726											
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphoma - advanced</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cervix & brain</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1-17</u> 19 <u>86</u> , to <u>1-24</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1-24</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John Mehan</u>						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-26-86	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MEHANNA, MD						23b. ADDRESS 909-B SETON DR., CUMBERLAND, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/27/86		23c. NAME OF CEMETERY OR CREMATORY Queens Point Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Keyser Mineral WV				
24. FUNERAL DIRECTOR NAME A. Craig Rotruck 85 S Main St Keyser, WV 26726						25a. DATE REC'D. BY REGISTRAR JAN 31 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Rodale			

041171

STURCK FURNACE HOME
55 E. MAIN STREET
KEYSER, IV 25726

JAMES
HEMMAN
VEEB

JANUARY 24, 1966

1:00P

ALLEANY COUNTY

SACRED HEART HOSPITAL

W. 1st Street, N. 1st Street

X

1966

229-82-7121

1966-1967

JOHN HEINMAN, MD

1966-1967

014096

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH DAY YEAR			2b. HOUR							
Mary Irene Weisenmiller						XX			1 6 1986			M							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) (LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR					
Female		Cau		09 18 1901		84 YRS.						1 6 1986		1515 M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland				USA								Allegany MD							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland				735 Fayette St				Housewife				Own Home							
13a. STATE												13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland												Allegany		Cumberland		X		735 Fayette / 21502	
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
Patrick Porter						Margaret Kreitzburg													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS							
No						219-54-1986						John Weslow - Route 2, Box 28 Frostburg, MD 21532							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
9293 IMMEDIATE CAUSE (a) Pulmonary arrest														sudden					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:														years					
(b) Chronic obstructive pulmonary disease																			
(c) DUE TO, OR AS A CONSEQUENCE OF																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)																			
Previously resected kidney for hemorrhage 1984; old hip fracture																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
Paul Snow, M.D.				Dpty				1/6/86											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Paul Snow, M.D.				Memorial Hosp. Cumberland Md 21502															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				Jan 9, 1986				Hillcrest Burial				Cumberland, Alleg., MD							
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D BY REGISTRAR											
John J. Hafer, Jr.				LaVale, MD 21502				JAN 10 1986											

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25M

BP

DHMM - 17
(VR A15 ME (5))

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U.S.A.
Houswife
Can Home

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English
1210-56-1986
John Keelaw -
Houswife
Can Home



John A. Keelaw, Jr.
1210-56-1986
Houswife
Can Home

031026

DIVISION OF VITAL RECORDS, 801 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
THOMAS FUNERAL HOME
101 GRANT STREET
SALISBURY, PA 15558
CERTIFICATE OF DEATH

REG. NO.

00102

1. DECEASED NAME (TYPE OR PRINT) CATHERINE E WELLINGTON			2a. DATE OF DEATH MONTH DAY YEAR 01 21 86		2b. HOUR 02:14AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 22 1926		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Brownsville, Pa	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Pa			13b. COUNTY Somerset	13c. CITY OR TOWN Boynton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Bernard Sheridan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Priscilla Wylie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 199206130	17. INFORMANT ADDRESS Thomas F Wellington Boynton, Pa 15532		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic coronary artery disease</u> years DUE TO, OR AS A CONSEQUENCE OF (c) <u>void</u> void					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>none</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1-19-</u> 19 <u>79</u> to <u>1-21</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>6-27-</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Grant Atwell, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-22-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Grant Atwell, M.D.		22e. ADDRESS Salisbury Pa. 15558			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1-24-86	23c. NAME OF CEMETERY OR CREMATORY SALISBURY CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SALISBURY - SOMERSET Pa.	
24. FUNERAL DIRECTOR NAME GARFIELD F THOMAS		ADDRESS 101 GRANT ST SALISBURY, PA 15558		25a. DATE REC'D BY REGISTRY JAN 27 1986	

041053

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic agent, the medical examiner must be notified at once.

FOR STATE REGISTRAR		ROTRUCK F.H. 85 S. MAIN STREET KEYSER, WV 26726		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) WALTER EDWIN WESTROM				2a. DATE OF DEATH MONTH DAY YEAR 01 26 86		2b. HOUR 20:10 M	
3. SEX Male		4. RACE Cau		5. DATE OF BIRTH MONTH DAY YEAR April 3 1910		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Minister	
13a. STATE WV		13b. COUNTY Mineral		13c. CITY OR TOWN Burlington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Victor Edward Westrom		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Woolhiser		13e. STREET ADDRESS / ZIP CODE Star Rt 1 Box 32 26710			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO --		16b. SOCIAL SECURITY NO. 516200792		17. INFORMANT ADDRESS Burlington, W.Va. Ora Westrom Star Rt 1 Box 32			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lactic acidosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Heart cell leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1-9</u> 19 <u>86</u> , to <u>1-26</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1-26</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>John Mehanne</u>				DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>1-27-86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MEHANNA, M.D.				22e. ADDRESS 909-B SETON DRIVE, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/29/86		23c. NAME OF CEMETERY OR CREMATORY Lahmansville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lahmansville WV	
24. FUNERAL DIRECTOR NAME A. Craig Rotruck 85 S Main St Keyser, WV 26726				25a. DATE REC'D. BY REGISTRAR FEB 03 1986			
				25b. REGISTRAR'S SIGNATURE <u>John Rotruck</u>			

DHMH - 10-60M 7-84
(VRA 15, 4)

041100

ROTHMAN, F.H.
25 S. MAIN STREET
KEYSER, VA 22726

ELIMIN WESTERN

WALTER

ALLEGANY COUNTY

SACRED HEART HOSPITAL

Star Rt 1 Box 35 26710

RAILROAD, W.VA.

Star Rt 1 Box 35 216200752



602-D SETON DRIVE, CINCINNATI, OH 45202

JOHN BERNARD, M.D.

FEB 03 1988

031114

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

GEORGE UPCHURCH F.H. 202 GREENE STREET CUMBERLAND, MD 21502				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 6 00104							
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
Carl Bell Whetzel				January 26, 1986				04:35am							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS. HOURS MIN.					
Male		White		May 20, 1921		64 YRS.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
West Virginia		U.S.A.				Allegany, County MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland		Sacred Heart Hospital				Potomac Edison		Company							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
Maryland Allegany Cumberland														12623-A McMullen Hwy. / 21502	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Lorenzo G. Whetzel				Gladys Dean											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO				17. INFORMANT ADDRESS							
Yes W.W.II				232267360/1				Mary Whetzel-Address same as #13 above.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY FAILURE</u>												30 MINUTES			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>BRAIN STEM INFARCTION</u>												6 weeks			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>ARTERIO SCLEROTIC C.V. DISEASE</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>12/13/85</u> to <u>1/26/86</u> , that (I) (we) last saw the deceased alive on <u>1/25/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Arvind Pathak</u>				DEGREE <u>MD</u>				22c. DATE SIGNED <u>1/26/86</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS											
Arvind Pathak M.D.				913 Seton Drive, Cumberland, Md. 21502											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				1-29-86		Sunset Memorial Park		Cumberland-Allegany-Maryland							
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Md. 21502				JAN 29 1986				<u>John A. ...</u>							

BP

GEORGE L. BROWN, M.D.
202 GREEN STREET
CHICAGO, ILL. 60601

Cardiologist Internist Family 28, 1988 04:35

Aluminum, Corrugated

General Heart Hospital

SECRET

CARDIO RESPIRATORY FAILURE 30 MINUTES
BRADYCARDIA INTRICATE
ARTHRITIS IN C.V. SYSTEM

1/24/88 1/24/88 1/24/88

1/24/88

1/24/88

215 Green Street, Chicago, Ill. 60601

George L. Brown, M.D.

031108

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary A. Whitefield			2a DATE OF DEATH MONTH DAY YEAR 01 24 86		2b HOUR 4:50 M
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 4 2 1905		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? usa	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10 CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lions Manor Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. General Motore Car		12b KIND OF BUSINESS OR INDUSTRY
13a STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE Seton Drive 21502	
14 FATHER'S NAME FIRST MIDDLE LAST George Simon Clark		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Ross			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 384-18-9290		17 INFORMANT ADDRESS Mrs. Norman Rankin Westernport, Md. 21562	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arterio Sclerotic peripheral vascular disease DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Multi infarction dementia.					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 1-17-84 to 1-24-86, that (I) (we) last saw the deceased alive on 1-17-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE V. A. Ranjithan		DEGREE		22c. DATE SIGNED 1-24-86	
22d PHYSICIAN'S NAME (CURRENT) V. A. Ranjithan, M. D.		22e ADDRESS LMNH, Seton Drive, Cumberland, MD 21502			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/28/86	23c. NAME OF CEMETERY OR CREMATORY Roseland Park		23d. LOCATION CITY OR TOWN COUNTY STATE Berkley Oakland Michagen
24 FUNERAL DIRECTOR NAME Boals Funeral Service Westernport, Md. 21562			25a DATE REC'D. BY REGISTRAR JAN 29 1986		25b REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper tags, and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DATE 11-20-50

X

1. General Police

2. Bureau of Investigation

3. Federal Bureau of Investigation

4. Department of Justice

5. Department of State

6. Department of Defense

7. Department of Education

8. Department of Health

9. Department of Labor

10. Department of Commerce

11. Department of Agriculture

12. Department of the Interior

13. Department of the Navy

14. Department of the Army

15. Department of the Air Force

16. Department of the Coast Guard

17. Department of the Marine Corps

036142

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, or medical condition, it should be marked on the back of this certificate.

MARKWOOD MCKENZIE FUNERAL HOME STATE OF MARYLAND
 1. FOR KEYSER, WVA 26726 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 REGISTRAR CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ARTHUR LEE WILMOTH			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 28, 1986			2b. HOUR 6:37 A.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 7, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chauffeur		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE W. Va.		13b. COUNTY Mineral		13c. CITY OR TOWN Keyser		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 98 James Street 26726	
14. FATHER'S NAME FIRST MIDDLE LAST Orland -- Wilmoth			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie -- Gainer			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 705 10 7692			17. INFORMANT ADDRESS Keyser, W. Va. Mrs. Arthur L. Wilmoth, 98 James St.						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cardiomegaly and</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 26 D	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>B. Mazzoni</u> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-28-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>B. Mazzoni</u>						22e. ADDRESS BMG 912 SETON DRIVE, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/31/86		23c. NAME OF CEMETERY OR CREMATORY Potomac Memorial Gardens, Keyser, Mineral, W. Va.		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Markwood-McKenzie Funeral Home, Keyser, W. Va.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

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ALLEGANY COUNTY

SACRED HEART HOSPITAL



ONE 212 SEVEN DRIVE, CLEVELAND, OH 44102

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Roselima Conner Wilson			2a. DATE OF DEATH MONTH DAY YEAR January 13, 1986		2b. HOUR 4:30 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 18, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1034 Frederick Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper	12b. KIND OF BUSINESS OR INDUSTRY Retail	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. CITY OR TOWN Allegany	13c. STREET ADDRESS 1034 Frederick St. 21502	
14. FATHER'S NAME FIRST MIDDLE LAST Harvey Conner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Eva Pressman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-05-5596	17. INFORMANT same as 13a-e.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CXIF</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>my</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
21g. I certify that (I) (this hospital) attended the deceased from <u>1/13/86</u> to <u>1/13/86</u> (or (I) (we) lost <u>1/13/86</u> above). (I) (we) (did) (did not) view the body after death.					
21h. SIGNATURE <u>W. Guy Fiscus</u>		DEGREE		21i. DATE SIGNED <u>1/14/86</u>	
21j. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. W. Guy Fiscus		21k. ADDRESS Cumberland, Maryland 21502 Memorial Hospital Building			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 1/14/86	23c. NAME OF CEMETERY OR CREMATORY Resthaven Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Fred. Maryland	
24. FUNERAL DIRECTOR NAME Leasure-Stein Funeral Home		25a. DATE REC'D. BY REGISTRAR JAN 16 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
230. BALTIMORE AVE. CUMBERLAND, MD 21502					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR BOALS FUNERAL HOME 111 CHURCH STREET WESTERNPORT, MD 21562				2a. DATE OF DEATH MONTH DAY YEAR 01/09/86			
1. DECEASED NAME (TYPE OR PRINT) CHARLES CEPHAS WILT		3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 19 1910	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7b. HOUR 10:28A	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Mechanic	
13a. STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Swanton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Theophilis George Wilt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Wilt		13e. STREET ADDRESS / ZIP CODE Rt2 Box 237 21561			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 217-03-6069		17. INFORMANT ADDRESS Mrs. Emma Wilt Swanton, Md. 21561			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Shock Probable Cardiac → Coma. DUE TO, OR AS A CONSEQUENCE OF (b). Possible Myocardial Infarction & Cardiac Shock DUE TO, OR AS A CONSEQUENCE OF (c). Severe CAD & CHF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes II on Insulin							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE not fixed yet	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21g. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/20/85 to 1/9/86, that (I) (we) lost saw the deceased alive on 1/9/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE V. Rual Felipa, MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/10/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. RUAL FELIPA, MD				22e. ADDRESS 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/11/86		23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Westernport Allegany Md.	
24. FUNERAL DIRECTOR NAME Wayne Boal				25a. DATE REC'D. BY REGISTRAR JAN 16 1986		25b. REGISTRAR'S SIGNATURE	
Boals Funeral Service Westernport, Md. 21562							

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4470 WEST BOX 107, WESTPORT, IN 47382

V. RIAL TELLY, MD

4470 WEST BOX 107, WESTPORT, IN 47382

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NEWMAN FUNERAL HOME
1- FOR STATE P.O. BOX 267
REGISTRAR GRANTSVILLE, MD 21536
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HARRY RUBEN WILT		2a. DATE OF DEATH MONTH DAY YEAR JANUARY 15, 1986		2b. HOUR 4:30 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6/6/1908		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Construction
13a. STATE Maryland		13b. COUNTY Garrett	13c. CITY OR TOWN Grantsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jesse --- Wilt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachael --- Platter		13e. STREET ADDRESS / ZIP CODE Route 2, Box 158 21536	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-12-9705		17. INFORMANT Mrs. Sarah A. Wilt Grantsville, MD 21536	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Ascard - Stroke</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12</u> 19 <u>85</u> to <u>1/15</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>1/15</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Wayne C. Spiggle, Jr.</u>		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne C. Spiggle, Jr. M.D.		22e. ADDRESS BMG, 912 SETON DR. CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/18/86	23c. NAME OF CEMETERY OR CREMATORY Grantsville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Grantsville, Garrett, MD	
24. FUNERAL DIRECTOR <u>S. Lynn Newman</u>		ADDRESS Grantsville, MD		25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 24 1986	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies, pages 1 and 2, and mail them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

NEWARK PUBLIC HOME

P.O. BOX 302

GRANTVILLE, MD 21740

HARRY RICHES WIFE

4:30 P

JANUARY 15, 1966

ALLEGANY COUNTY

SACRED HEART HOSPITAL

311-11-2702

CLARKVILLE, MD 21030
RMC 212 SECH CO.

029109

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM LEVI WINNER			2a. DATE OF DEATH MONTH DAY YEAR January 20, 1986		2b. HOUR 7:55 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 18, 1916		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HRS. MIN. 69	7. IF UNDER 1 YEAR MONTHS DAYS HRS. MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter	12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN LaVale	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Cash Valley Road/21502	
14. FATHER'S NAME FIRST MIDDLE LAST Peter Clarence Winner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Katherine Price		16. SOCIAL SECURITY NO. 44438	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) Yes WW II		16b. SOCIAL SECURITY NO. 220-10-7671		17. INFORMANT Wm. C. Winner 591 Brookfield Ave. Masury, Ohio	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC and RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF: (b) HEPATO-RENAL SYNDROME DUE TO, OR AS A CONSEQUENCE OF: (c) LAENNEC'S CIRRHOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) GASTROINTESTINAL BLEEDING due to ESOPHAGEAL VARICES					
19a. DATE OF OPERATION 1-16-86	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED OBSTRUCTIVE JAUNDICE due to COMMON DUCT STONES	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M.	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) did (did not) view the body after death.					
22b. SIGNATURE <i>Dr. Amado Torres</i>		DEGREE M.D.	22c. DATE SIGNED 1/20/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Amado Torres
22e. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502		22f. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/24/86	23c. NAME OF CEMETERY OR CREMATORY Brookfield Twsp.	23d. LOCATION CITY OR TOWN COUNTY STATE Brookfield Trumbull Oh.		
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr.		ADDRESS LaVale, Md. 21502	25a. DATE REC'D. BY REGISTRAR JAN 27 1986	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner will be notified.

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FOR
STATE 85 S. MAIN ST.
REGISTRAR KEYSER, WV 26726

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LEWIS RAYMOND WOLFORD			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 9, 1986			2b. HOUR 6:50 P.M.			
3. SEX Male		4. RACE Cau		5. DATE OF BIRTH MONTH DAY YEAR Dec 24 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Govt		12b. KIND OF BUSINESS OR INDUSTRY Postal Service	
13a. STATE WV		13b. COUNTY Mineral		13c. CITY OR TOWN Keyser		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 117 E. Piedmont Street 26726	
14. FATHER'S NAME FIRST MIDDLE LAST Henry McCoy Wolford				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rhoda Albright					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT Pauline L. Wolford		ADDRESS 117 E. Piedmont St Keyser, WV 26726			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction & cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Respiratory Failure</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the _____ day and hour and from the causes stated above, (I) (we) (did) not view the body after death.									
22b. SIGNATURE <u>Baljeet Mahal</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BALJEET MAHAL						22e. ADDRESS 909-B SETON DR. CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/12/86		23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Westernport Allegany MD		
24. FUNERAL DIRECTOR NAME A. Craig Rotruck 85 S Main St Keyser, WV 26726						25a. DATE REC'D. BY REGISTRAR JAN 16 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rodgers</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use by the funeral director. These pages should be removed from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

023107

ROTHMAN BARBARA HENRY
85 S. MAIN ST.
NEWBERY, WA. 98270

LEWIS RAYMOND WILFORD

ALLIANCE COUNTY

SACKETT LEVY HOSPITAL

722-16-2072

Intermittent test results
Positive - suggestive of infectious etiology

Respiratory failure

Barney

BARRETT HANNAH

CLINICAL (MD) 21502
REG-5 SECTOR DR.

010088

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

00112

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

Mary

Eva

Yarnall

2a DATE KNOWN
OF ESTI-
DEATH MATED

MONTH DAY YEAR
1 5 86

2b HOUR
M

3 SEX
Female

4 RACE
Cau

5 DATE OF BIRTH
MONTH DAY YEAR
OCT. 2, 1900

6 AGE (IN YEARS)
LAST BIRTHDAY
85 YRS.

IF UNDER 1 YR.
MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN.

7c DATE
PRONOUNCED
DEAD

MONTH DAY YEAR
1 5 86

7d HOUR
M

7a BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Maryland

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☒

9 BALTIMORE CITY OR COUNTY OF DEATH

Allegany

MD.

10 CITY OR TOWN OF DEATH
Cumberland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1105 Frederick Street

12a USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
Practical Nurse

12b KIND OF BUSINESS
OR INDUSTRY
Medicine

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE
Maryland

13b COUNTY
Allegany

13c CITY OR TOWN
Cumberland

13d. INSIDE CITY LIMITS?
YES ☒ NO ☐

13e STREET ADDRESS
1105 Frederick Street / 21502

14 FATHER'S NAME
FIRST MIDDLE LAST
John Vincent Yarnall

15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth T. Hart

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No --

16b. SOCIAL SECURITY NO.
183-12-5820

17. INFORMANT
ADDRESS
Mary Y. Brake - Chevy Chase, Maryland

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio-pulmonary arrest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

sudden

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Acute congestive heart failure

minutes

DUE TO, OR AS A CONSEQUENCE OF

(c) Cardio-vascular heart disease

years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I have charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL
SIGNATURE

TITLE (SPECIFY)

M.D. Dpty MEDICAL EXAMINER

DATE 1/5/86
SIGNED

EXAMINER'S NAME
(TYPE OR PRINT)

Paul Snow, M.D.

ADDRESS Memorial Hosp. Cumberland Md 21502

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial

23b. DATE
1-8-86

23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery

23d. LOCATION
CITY OR TOWN COUNTY STATE
Cumberland-ALlegany Co.-MD.

24 FUNERAL DIRECTOR
NAME ADDRESS
George-Upchurch Funeral Home, P.A.
202 Greene Street-Cumberland, Md. 21502

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

JAN 8 1986

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

92814 140703

ONE

WIKI



[Handwritten signature]